Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 21, 2017	2017_601532_0014	023964-17	Resident Quality Inspection

Licensee/Titulaire de permis

KNOLLCREST LODGE LIMITED
50 William Street, Milveton PERTH ON N0K 1M0

Long-Term Care Home/Foyer de soins de longue durée

KNOLLCREST LODGE
50 WILLIAM STREET MILVERTON ON N0K 1M0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

NUZHAT UDDIN (532), JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 23, 24, 25, 26 and 27, 2017.

Critical Incident System (CIS) inspection # 532-000013-17 log# 004984-17 related to physical and verbal abuse was completed.

During the course of the inspection, the inspector(s) spoke with Chief Executive Operator (CEO), Director of Resident Care(s) (DRCs), Resident Assessment Instrument (RAI) Coordinator, Environmental Service Manager, Recreation and Program Services Manager, Registered Nurses (RN), Behaviour Support Ontario Staff (BSO), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff, Family and Resident Council Representatives, Residents and Family members.

Inspectors also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant residents clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Resident observation showed that an identified resident had assistive devices.

Plan of care for the resident stated that the identified resident used the assistive devices.

In an interview the identified resident acknowledged that they used one of the assistive devices.

Clinical record review stated that there was no documented assessment for the resident in accordance with evidence-based practices.

In an interview the RAI Coordinator shared that the assistive device was discussed within the managers and it was decided that since they do not restrict resident movement that a resident assessment was not warranted. The RAI Coordinator acknowledged that an assessment should have been completed where the assistive devices were used and it was not done. The RAI Coordinator acknowledged that the assessments for the assistive devices were not done for any of the residents in the home.

The licensee has failed to ensure that where the assistive device was used, the identified resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails were used, has the resident been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Critical Incident System (CIS) report was submitted to the MOHLTC, documented that there was staff to resident physical and verbal abuse. There was injury noted by the witness at the time of the incident. The incident was reported to the CEO the following day.

Record review indicated that the identified resident was assessed the following day, by a registered nurse and it indicated that the identified resident had no recollection or memory of the events within the past 24 hours and no injury was evident at the time.

Record review indicated that the resident had responsive behaviours and was managed with medications.

During Ministry of Health (MOH) internal investigation of this CIS, it was discovered that there were three other reported incidents involving the alleged staff member, however, there was no documentation of the two reported incidents and no record of any conversation in the alleged staff’s personal file.

Record review of the alleged personal file indicated that there was a letter provided to the alleged staff indicating that the investigation related to the CIS was complete and that witness reports indicated the alleged staff had spoken to the resident in a rude, disrespectful and threatening manner.

The CEO acknowledged the allegations of abuse.

The licensee failed to ensure that identified resident was protected from abuse when an alleged staff spoke to the resident in a rude, disrespectful and threatening manner and caused injury. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

Policy called Prevention of Abuse and Neglect stated under interventions "to stop abuse that staff have a moral obligation to intervene and speak out when resident abuse is suspected to advocate for the vulnerable resident. If abuse is witnessed, separate the parties' involved. Attend to the resident. Seek the charge nurse/management involvement immediately. The supervisor is expected to immediately send an employee away from the workplace with pay until further notice, pending a thorough investigation and decision regarding disciplinary action and accusations of abuse."

The Critical Incident System (CIS) report was submitted to the MOHLTC, documented that there was staff to resident physical and verbal abuse. There was injury noted by the witness at the time of the incident. The incident was reported to the CEO the following day.

In an interview the staff member that witnessed said that they had education on zero tolerance of abuse and were aware of their obligations to report abuse right away but they were not sure why they didn't tell the registered staff and acknowledged that there was an RN working at the time of the incident. The staff member shared that they went to the CEO the next day and did not tell the registered staff at the time of the incident.

In an interview another staff member shared that the staff member that witnessed verbal and physical abuse did confide about the incident after it happened and they both decided to tell management. This staff member acknowledged that they had zero tolerance of abuse education and were aware of immediate reporting protocols and shared that they reported the incident the next day when they returned to work and acknowledged that they did not report it immediately to the oncoming RN.

This incident was confirmed by DRC and they acknowledged that the staff members were to report the incident to their immediate supervisor and seek the charge nurse immediately, however, the reporting of abuse did not happen till the following day. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Policy on Prevention of Abuse and neglect stated that "police shall be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident the licensee suspects may constitute a criminal offence."

The Critical Incident System (CIS) report was submitted to the MOHLTC, documented that there was staff to resident physical and verbal abuse. There was injury noted by the witness at the time of the incident. The incident was reported to the CEO the following day.

The CEO acknowledged that the police force was not notified regarding this incident of abuse. The Policy and the regulation was shared with the CEO and they acknowledged that they should have notified the police but did not.

The licensee has failed to ensure that the appropriate police force was immediately notified after the incident of abuse. [s. 98.]

Issued on this 22nd day of November, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.