Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
March 23, and 24, 2011	2011_170_2917_23Mar071525	Critical Incident L-00333

Licensee/Titulaire
Devonshire Erin Mills Inc., 195 Dufferin Avenue, Suite 800, London, ON N6A 1K7

Long-Term Care Home/Foyer de soins de longue durée
Lanark Heights Long Term Care Centre, 46 Lanark Crescent, Kitchener, ON N2N 2Z8

Name of Inspector(s)/Nom de l'inspecteur(s)
Dianne Wilbee #170

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to a staff to resident abuse.

During the course of the inspection, the inspector spoke with: Regional Manager Resident Care for Sifton, Regional Manager for Diversicare Consultant, Project Coordinator for Sifton, Director of Care, Assistant Director of Care, Environmental Services Manager, Support Services Coordinator, Registered Practical Nurse (1), Personal Support Workers (9).

During the course of the inspection, the inspector: Reviewed the home's investigation, reviewed Resident Abuse: Reporting and Investigation policy, toured home area, observed resident, observed resident's room, reviewed resident's record.

The following Inspection Protocols were used in part or in whole during this inspection:

- Prevention of Abuse, Neglect and Retaliation

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8, s.23(1)(a)(i)**
Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone

Findings:
The alleged abuse was not immediately investigated by the manager who was first informed of the allegation.

Inspector ID #:	170

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 with the legislative requirement to immediately investigate abuse of a resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with **LTCHA, 2007, S.O. 2007, c.8, s.24(1)2.**
(1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Findings:
Staff informed of an alleged abuse including the staff member present at the time of the alleged abuse did not immediately report the abuse.

Inspector ID #:	170

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 with the legislative requirement to immediately report alleged, suspected or witnessed abuse of a resident, to be implemented voluntarily.

WN #3: 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.

Findings:
The home did not immediately notify the police of an abuse situation.

Inspector ID #:	170

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 with the legislative requirement to immediately notify the police of any alleged, suspected or witnessed incident of abuse, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Diane Wilbee
Title: **Date:**	**Date of Report:** April 5, 2011