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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

	Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public
Date(s) of inspection/Date de l'inspection January 26, 27, 28, 2011	**Inspection No/ d'inspection** 2011_102_9531_26Jan103323	**Type of Inspection/Genre d'inspection** Log # O-000142 Critical Incident

Licensee/Titulaire
The Corporation of the County of Northumberland
983 Burnham Street
Cobourg, Ontario K9A 5J6 Fax # 905 372 8525

Long-Term Care Home/Foyer de soins de longue durée
Golden Plough Lodge
983 Burnham Street
Cobourg, Ontario K9A 5J6 Fax # 905 372 8525

Name of Inspector(s)/Nom de l'inspecteur(s)
Wendy Berry (102)

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: the Administrator, Director of Care, Assistant Director of Care, several registered and non registered nursing staff, several residents and several visitors; two Human Resources staff.

During the course of the inspection, the inspector: reviewed the chart, progress notes, Kardex and the "Daily Record Flow Sheet" of a resident; observed the identified resident and her room; obtained the Abuse Policy; reviewed 2010 attendance records for mandatory education training; received a copy of the "Mandatory Education Day 2010" booklet.

The following Inspection Protocol was used during this inspection: Prevention of Abuse and Neglect.

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

4 WN
1 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 O. Reg. 79/10, Sec. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision maker, if any, and any other person specified by the resident, (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Findings:

1. On January 06, 2011, Director of Care (DOC), was informed by a member of the nursing staff, that on January 01, 2011, she had been returning from a break and heard an identified resident crying. Another staff member was observed in the room of the identified resident. The resident was observed to have a towel over her face. A staff member was observed pushing the resident's head into a pillow and saying "shut up" to the resident. The incident was reported to the Registered Nurse.
2. On January 19, 2011, the DOC contacted the Ottawa Service Area office by telephone to report the allegation of abuse and that an investigation was in progress. The DOC indicated that the family of the resident had not been notified of the alleged abuse.
3. The resident's substitute decision-maker (SDM) was not notified within 12 hours of the licensee becoming aware of a suspected or witnessed incident of abuse.
4. On January 19, 2011, the DOC placed a call to the resident's SDM.

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WN #2: The Licensee has failed to comply with O. Reg. 79/10, Sec. 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 offense.

Findings:

1. On January 06, 2011, the Director of Care (DOC) was informed by a nursing staff member that on January 01, 2011, she had been returning from a break and heard an identified resident crying. A staff member was observed in the room of the identified resident. The resident was observed to have a towel over her face. The staff member was observed pushing the resident's head into a pillow and saying "shut up" to the resident. The incident was reported to the Registered Nurse.
2. On January 19, 2011, the DOC contacted the Ottawa Service Area office by telephone to report

the allegation of abuse and that an investigation was in progress. The DOC indicated that the police had not been notified of the alleged abuse.
3. On January 19, 2011 the DOC contacted the Cobourg Police.

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WN #3: The Licensee has failed to comply with O. Reg. 79/10, Sec. 104.(2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Findings:

1. On January 06, 2011, the Director of Care (DOC) was informed by a nursing staff member that on January 01, 2011, she had been returning from a break and heard an identified resident crying. A staff member was observed in the room of the identified resident. The resident was observed to have a towel over her face. The staff member was observed pushing the resident's head into a pillow and saying "shut up" to the resident. The incident was reported to the Registered Nurse.
2. On January 19, 2011, the DOC contacted the Ottawa Service Area office by telephone to report the allegation of abuse and that an investigation was in progress. A written report was submitted and received on the same date.
3. The Licensee did not make a report to the Director under subsection 23(2) of the Act, within 10 days of becoming aware of the alleged abuse.

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WN #4: The Licensee has failed to comply with The Long Term Care Homes Act, 2007, C. 8, 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.

Findings:

1. The licensee has in place, "Policy No.: EC18-06" titled "Prevention, Reporting and Elimination of Elder Abuse".
2. Page 3 of 10 identifies "The Reporting of Abuse". The policy states "Staff and volunteers of Golden Plough Lodge who witness or suspect the abuse of an Elder, or who receive complaints of abuse, MUST report the matter without delay to their immediate supervisor, who must then immediately forward notification to the Administrator".
3. On January 01, 2011, a nursing staff member reported to the R.N., that she had witnessed the abuse of a resident by another staff member. The R.N. did not forward any notification to the Administrator, of the complaint of the abuse. The home's policy was not complied with.

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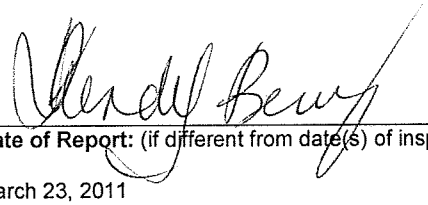
Additional Required Actions:

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 the abuse policy of the home is complied with by all staff, 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. 
Title: Date:	Date of Report: (if different from date(s) of inspection). March 23, 2011