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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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
May 18 & 19, 2011	2011_121_8532_18May145420	Critical Incident L-000617

Licensee/Titulaire
Knollcrest Lodge, 50 William St., Milverton ON N0K 1M0

Long-Term Care Home/Foyer de soins de longue durée
Knollcrest Lodge, 50 William St., Milverton ON N0K 1M0

Name of Inspector(s)/Nom de l'inspecteur(s)
Elizabeth Elvidge #121

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection relating to abuse/neglect.

During the course of the inspection, the inspector spoke with the Administrator, the Director of Care and 2 Registered nurses.

During the course of the inspection, the inspector reviewed the documentation related to the identified resident and the Policy on Zero tolerance of abuse.

The following Inspection Protocols were used in part or in whole during this inspection:
Prevention of Abuse/Neglect

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

6 WN
6 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, s23(1)(a)(ii)

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:

(ii) neglect of a resident by the licensee or staff,

Findings:

Documentation on a critical incident report, a progress note dated 4-15-2011 and an internal incident report completed on 4-14-2011 after a fall all provided evidence of neglect.
An investigation was not completed.

Inspector ID #:	121

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 so that all incidents of abuse/neglect are identified and investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s24(1)2

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:

An incident was assessed by Management as an injury that resulted in a transfer to hospital. It was not Identified as abuse/neglect until May 18, 2011.
The Director has not received a report of the incident.

Inspector ID #:	121

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 so that all alleged/suspicion of/abuse be reported to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s6(7)
The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:
The Plan of Care indicates one staff is to remain with the resident while she is on commode. Progress note dated 4/15/2011, a late entry for 4/14/2011 stated the staff member left resident unattended in the bathroom and went out into the resident's room to turn off roommate's TV.

Inspector ID #:	121

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 so that the care identified on the plans of care of the residents is received by the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg. 79/10, s104(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;
An incident was Identified as Abuse/Neglect on May 18/11. To date, the Director has not received a report.

Inspector ID #:	121

WN #5: The Licensee has failed to comply with O.Reg. 79/10, s.8(1)(a)
Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act;

Findings:
The home's Policy and procedure for Resident Abuse and Neglect states the following:
1. The Regional Office is to be notified by telephone or on-line critical incident within 24 hrs. of having determined that abuse has taken place or is likely to have taken place.
2. The home has 1 month to complete the inspection and report to the Director.
The above is not in compliance with the applicable requirements under the Long Term Care Homes Act, 2007.

Inspector ID #:	121

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 the policy/procedure on zero tolerance of abuse/neglect is in compliance with applicable requirements under the Act/Regs. to be implemented voluntarily.

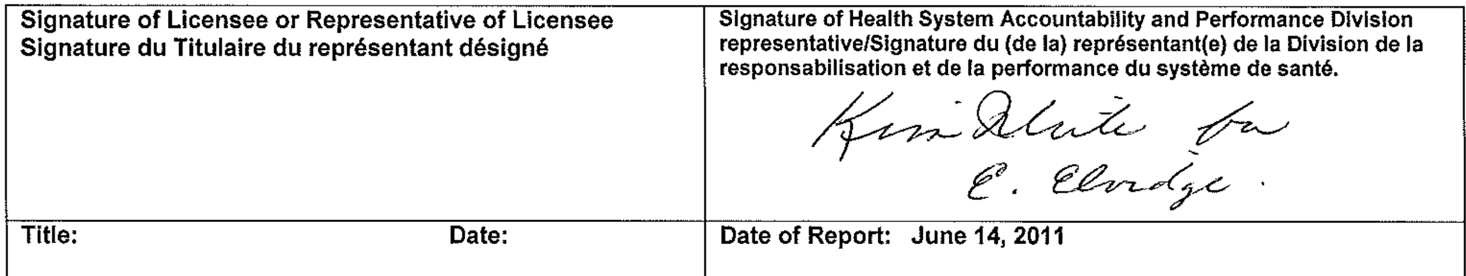
WN #6: The Licensee has failed to comply with O.Reg. 79/10, s.8(1)(b)
Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(b) is complied with.

Findings:

The home's Policy and Procedure for Resident Abuse and Neglect was not followed. There was no evidence of investigation of the incident, no evidence of appropriate action taken and no evidence of notification of the Director. In addition, there was no evidence of notification of the SDM of the results of the investigation, nor of the Director of the results of the investigation or the current status of the individual involved in the incident. The home's zero tolerance policy was not upheld.

Inspector ID #:	121

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 all cases of abuse/neglect are identified, reported and investigated in compliance with applicable requirements under the Act/Regs. 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: June 14, 2011