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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 10, 2014	2014_348143_0020	O-001066-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF HASTINGS
1M Manor Lane, Box #758, BANCROFT, ON, K0L-1C0

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

HASTINGS CENTENNIAL MANOR
1 MANOR LANE, P.O. BOX 758, BANCROFT, ON, K0L-1C0

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

PAUL MILLER (143), HUMPHREY JACQUES (599), JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 27th-31st and November 3rd to 6th, 2014.

The following Complaint logs #O-001039-14, #O-000944-14, #O-000386-14 and Critical Incident Logs #O-000800-14, #O-000450-14 were completed during the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Long Term Care Services, the Site Supervisor, the Director of Nursing, a Registered Dietitian, the Food Service Supervisor, the Environmental Services Supervisor, the Environmental Services Manager, a physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Dietary Aides, Personal Support Workers (PSW), the staffing clerk, Resident Council and Family Council representatives, family members and residents.

During the course of the inspection, the inspector(s) observed resident care and services, completed tours of all resident home areas, observed meals and snack service, observed medication administration, reviewed infection control practices, reviewed policies and procedures related to fall prevention, abuse, complaints, responsive behaviors, restraints, nutrition as well reviewed resident health care records inclusive of assessments, plans of care, physician orders, consults and progress notes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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 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 :

1. The following finding is related to Critical Incident Inspection Log # O-000450-14:

Ontario Regulation 79/10 section 2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

"emotional abuse" means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviors or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident,

"verbal abuse" means,
(a) any form of verbal communication of a threatening or intimidation nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident,

On a specified date Resident #3707 reported to S101 (RPN) that a PSW, S121 had told her\him to shut up. The home immediately began an investigation and submitted a Critical Incident Report to the Ministry of Health and Long Term Care. The home's investigation confirmed that the complaint from the resident was founded. The homes final investigation indicated that the staff had demonstrated unprofessional conduct, unethical behavior and was verbally and emotionally abusive to the resident. Administrative staff disciplined S121 according to the County of Hastings Human Resource Manual, Policy #8 Discipline. [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 all residents are protected from verbal and emotional, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care identifies resident sleep pattern and preferences.
During stage one of the Resident Quality Inspection a family member identified that resident #4056 sleep patterns and nap preferences were not respected. The family member indicated that the resident always had a rest in the afternoon prior to living in the home. The family member reported that she\he will often find resident #4056 sleeping in her\his wheelchair.
A review of the plan of care for resident #4056 indicated that sleep patterns and preferences were not identified within the plan. On October 30th, 2014 S104 (RPN) as well the Director of Care reviewed Resident #4056 plan of care and confirmed that sleep pattern and preferences were not identified. [s. 26. (3) 21.]

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 all residents have sleep patterns and rest preferences identified within their plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that a physician or a registered nurse in the extended class has ordered or approved the restraining of a resident.

The Home's policy H-5 entitled Least Restraint, last Resort Program page 2, indicated physical restraint could include 2 bed rails and page 3 under policy Highlights it is stated in collaboration with the multidisciplinary team, only the physician or RNEC can order a restraint.
The Home policy H-5 entitled Least Restraint, last Resort Program page 2, indicated physical restraint could include seat/lap belt and page 3 under policy Highlights it is stated in collaboration with the multidisciplinary team, only the physician or RNEC can order a restraint.

On a specified date, inspector #599 observed resident #6198 in bed with two full bed rails up.
Staff #111 reported to Inspector #599 that Resident #6198 can not get out of bed on her\his own and the sides rails are used as restraint. A review of the resident #6198 personal health information record and the last medication review form signed by the physician indicated that a current order for the use of bed rails restraint was not in place. Staff #111 confirmed with Inspector #599 that there was not a written order for the bed rail restraint.

On a specified date, Inspector #599 observed Resident #4056 in the dining room sitting in her\his wheelchair with a front locking seat belt. Staff #113 reported to the Inspector that Resident #4056 has a front locking seat belt as a restraint and that the resident is monitored hourly and it is documented in Point of Care.
On a specified date, inspector #599 observed resident #4056 in a wheelchair with the seat belt restraint applied.
A review of resident's #4056 personal health information records did not indicate there was a physician's order for the front locking seat belt and that the restraint had been discontinued. [s. 31. (2) 4.]

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 all residents who require the use of restraints have current physician orders in place, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that desired bedtime and rest routines are supported and individualized to promote comfort, rest and sleep.
During stage one of the RQI a family member reported that Resident #4056 always had a nap in the afternoon. The family member reported that she\he visits her\his parent often and that she\he will often find Resident #4056 sleeping in her\his wheelchair. Resident #4056 was observed by Inspector #143 sleeping in her\his wheelchair in the hallway at a specified time. Staff (S) S107 (PSW) was interviewed by the inspector in respect of the residents bedtime and rest routines. S107 reported that Resident #4056 is a resident who is an early riser and often will be up at 0630. S107 was questioned if the resident was usually awake at that time of day and reported to the inspector that staff would wake the resident up. S107 was questioned if the resident would nap in the afternoon and reported that most days the resident would not. Reported that a family member will put the resident to bed. S107 reports that the resident will generally go to bed after supper and would be in bed by 1930 hours. S108 (PSW) reported to the inspector that she\he works evenings and that her \his shift starts at 1430 hours. S108 reports that the resident is always up at that time of day and was unsure if the resident naps earlier in the afternoon. [s. 41.]

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 all residents have their individualized bedtime and rest routines identified and support to promote comfort, rest and sleep, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) 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 applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee has failed to comply with their Resident and Family Complaint Policy and Procedure H-15.

The following finding is related to Complaint Log O-000944-14.

Ontario Regulation 79/10 section 100. Complaint procedure:licensee indicates the following.
Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101.

A review of Hastings County Long-Term Care Staff Resource Manual Policy/Procedure Resident and Family Complaints H-15 page 3 0f 7 indicated the following;
Written Complaints
Written complaints should be forwarded to a a Manager\Supervisor of the home.

On a specified date Resident #2 had responsive behaviors towards resident #4046, family members and staff. Resident #4056 was not injured.
On a specified date the complainant provided a written complaint of the incident to RN S116. The Site Supervisor reported to Inspector #143 that S116 confirmed with her receiving the written letter of complaint. S116 reported that she\he forwarded the letter of complaint to another RN S117. The Site Supervisor reported that this letter was not forwarded to a Manager\Supervisor of the home. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

On a specified date Resident #9523 was diagnosed with an infection.

During an interview, the Director of Nursing indicated to Inspector #550 it is the home's expectation that staff record symptoms of infection for residents on every shift in the progress notes in point click care.

Inspector #550 reviewed Resident #9523's progress notes in point click for a specific period of time over the course of twelve days. There was no documentation of the symptoms of this resident's infection documented on every shift except for two days. The Director of Nursing reported to the inspector she was unable to find documentation of the symptoms for that same period of time.

As such the staff failed to record symptoms of the infection for this resident. [s. 229. (5) (b)]

Issued on this 10th day of November, 2014

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