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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 28, 2015	2015_280541_0034	O-002657-15	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

AMBER MOASE (541), SUSAN DONNAN (531), WENDY BROWN (602)

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 19-23 and October 26, 2015

A Critical Incident was inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Environmental Services Manager, the Food Services Manager, the Registered Dietitian, Registered Nurses, Registered Practical Nurses, the RAI coordinator, Maintenance staff, Personal Support Workers, President of the Resident and Family Councils, Residents and Family members. The inspectors also reviewed resident health care records, observed resident meal service, medication administration and staff to resident interactions and reviewed relevant policies and meeting minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

- **3 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #021 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

On October 22, 2015 during an observation of the lunch meal, Inspector #541 noted dietary staff #S113 provide a modified texture meal to resident #021. During an interview with dietary staff member #S113, she indicated to Inspector #541 that resident #021 has been receiving this modified texture for at least 2-3 months and this is the only diet texture offered to the resident.

The home's Registered Dietitian (RD) staff #S115 was interviewed by Inspector #541 and she indicated resident #021 receives a different diet texture than what was provided at lunch. A review of resident #021 most current nutritional care plan also indicates resident #021 receives a different diet texture than what was provided at lunch.

RD staff #115 indicated to Inspector #541 during an interview that a registered staff member can change a resident's diet for 24 hours if that is deemed necessary and if this is done, they would then notify the RD to have the diet changed. RD staff #S115 stated to Inspector #541 that upon review of resident #021's progress notes, she found a note from July 2015 indicating resident does occasionally receive the modified diet texture. Inspector informed RD that this resident, according to dietary staff #S113, is only offered the modified diet texture and is no longer offered the diet texture as ordered, RD was not aware of resident #021 was only offered this modified diet texture.

It is noted resident #021 has had a significant weight loss over a four month period. As per resident #021's progress notes, resident #021 was assessed for a significant weight loss on a specified date by the home's RD. The assessment indicates the resident occasionally receives the modified diet texture. There were four further assessments completed by the home's registered dietitian over a three month period for a significant weight loss. There is no indication in any of the four assessments that resident #021's diet texture was re-assessed. During the most recent assessment by the home's registered dietitian on a specified date, the assessment indicates resident #021 receives the diet texture as ordered.

The home failed to ensure that resident #021 plan of care was reviewed and revised when the resident's care needs changed as resident #021 continued to be provided with a modified diet texture that was not ordered for at least 3 months, without this being assessed by the home's Registered Dietitian and the plan of care revised. [s. 6. (10) (b)]

2. According to resident #033's current care plan, the resident has depressive symptoms. The current care plan reflects specific depressive symptoms exhibited by resident #033. According to the care plan, interventions to manage resident #033's symptoms of depression include ensuring the resident has 1:1 visits to provide reassurance and redirection as well as consultations with a social worker.

The home uses a software program called ActivityPro to document all residents involvement in activity and recreation. During an interview with Inspector #541, the Activity Program Manager indicated that this program would reflect any 1:1 visits a resident has. Inspector #541 reviewed the Activity Pro report for resident #033 for the month of September and October 2015 and noted the resident was not involved in any group or 1:1 activities for the time period.

During an interview with Inspector #541 activity staff #S117 stated to the inspector that she used to work on the unit where resident #033 resides and she does not think the resident would accept any 1:1 activities unless it involved specific discussion around the resident's interests. Staff #117 further stated that when she worked on the unit with resident #033 the resident refused a consultation with a social worker. The Director of Nursing confirmed during an interview with Inspector #541 that she does not believe resident #033 is regularly seen by a social worker.

The licensee failed to ensure that resident #033's needs were reassessed and the plan of care reviewed and revised when the interventions noted to manage the resident's

depressive symptoms were no longer in place. [s. 6. (10) (b)]

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 will be reassessed and their plans of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following areas of disrepair were noted by Inspectors #531 and #541 throughout this inspection:
Tub room #116 Thanet street home unit: Lower walls on both sides of the tub multiple drywall patches, unfinished along both walls and corner sections covering scarred areas. Drywall patches corner centre wall rough plaster covering scarred sections of the wall, unfinished, not sanded or painted.

Thanet street common area: left and right entrance wall into TV lounge scarred with

drywall patches.

Hybla Street home unit: large activity room has numerous grey duck taped areas over seams in the floor from 1 to 4 feet in length.

Cheddar street home area: This is the secure unit of the home. At the entrance to the snoozelin room, over 10 patches have been repaired with plaster along wall of entrance and walls in the room; none of the patches have been painted. At entrance to snoozelin room there is a piece of the lower baseboard missing approximately 6 inches, bare, uneven wall exposed.

Cheddar street unit room #56: right wall has multiple drywall patches that have been sanded and unfinished, wall to the right of the bathroom door is heavily scarred, paint gouged, unfinished aged drywall plaster lower 6' -plaster has been damaged over the plastered areas.

Cheddar street unit room #22: inside entrance wall 4 feet from the floor there are four aged unfinished drywall patches -centre of the right wall multiple gouges in the drywall, paint chipped -corner wall to the left of the bathroom door lower 4 feet of the wall multiple gouges in the wall with aged unfinished drywall patches that have been damaged over the unfinished plaster.

During an interview with Inspector #541, the Environmental Services Manager (ESM) indicated that the home uses a software program that triggers preventative maintenance to be completed. The ESM indicates that when work is needed anybody can access the software program to enter a work requisition for maintenance and he also completes regular audits of the home areas. When asked if he was aware of the disrepair in the Cheddar Street unit, the ESM stated he is aware this unit requires more work than the other units but could not confirm he was aware of the disrepair.

PSW staff #S125 has worked on Cheddar street unit for the past year and indicated in an interview with Inspector #531 that the disrepair has been present since she started.

RPN staff #S126 has been working on the secure unit for the past six months and states during that time the walls have been repaired but no painting has been done.

Maintenance staff #S127 indicated to Inspector #531 during an interview that there is no scheduled preventative maintenance for the home. S127 stated the resident rooms take

priority and work in the common areas of the home is completed when there is time. Maintenance staff #S127 showed Inspector #541 and #531 documentation of the last work completed in the Cheddar street unit and this work was completed April 2014. [s. 15. (2) (c)]

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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee responded in writing within 10 days of the receiving the advice.

On October 22, 2015 during an interview with the family council representative and review of the Family Council minutes posted March 25, 2015 it was confirmed that the Family Council brought forward the following three concerns:
-lack of access to the outside yard from the Cheddar secure unit the door magnet was not working
-smoking residents require some type of shelter space to smoke in inclimate weather
-computer access, wi-fi availability for resident usage. When will it be available?

The family council member indicated that he approached the Environmental Services Manager (ESM) in June regarding the concerns prior to adjourning for the summer and he was going to follow up with corporate office. The member confirms that council has not currently received a written response to the concerns.

On October 23, 2015 the ESM was interviewed, acknowledged the concerns and confirmed that the council does not always receive a written response to concerns. [s. 60. (2)]

Issued on this 30th day of October, 2015

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

Original report signed by the inspector.