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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jul 5, 2017	2017_589641_0019	035355-16, 001364-17, 003298-17, 007633-17, 008160-17, 011135-17	Critical Incident System

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

CATHI KERR (641)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 22, 23, 26, 27, 28, 29, 30, 2017

This inspection was conducted in reference to four critical incidents related to alleged resident to resident abuse, log #008160-17, #011135-17, #035355-16, and #007633-17; one critical incident related to a resident falling resulting in an injury, Log #003298-17; and one critical incident related to alleged emotional abuse of a resident by a visitor, Log #001364-17.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Nursing (DON); Registered Nurses (RN); Registered Practical Nurses (RPN); Personal Support Workers (PSW); Physiotherapist (PT); residents; and resident's family members.

As well, the Inspector observed resident care, reviewed resident heath care records and relevant policies and procedures related to falls prevention, least restraint and zero tolerance of abuse and neglect.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A critical incident was submitted to the Director related to an altercation that occurred on a specified date between residents #006 and resident #007 that resulted in resident #007 sustaining an injury.
The Director of Nursing, DON #104, indicated to Inspector #641 that she became aware of the incident three days later when she read the progress notes related to this incident, and further indicated that RPN #110 had not notified the Director immediately upon being aware of the incident, as was the expectation of the licensee.

A critical incident was submitted to the Director related to suspected abuse of resident #009 by resident #008, which occurred on a specified date.
DON #104 indicated to the Inspector that RN #111 had not reported this incident immediately to the Director by calling the afterhours number, as she had been trained to do in the mandatory training that she had received annually, including in December 2016. DON #104 indicated that she became aware of this incident after reading the residents' progress notes four days after the incident and reported it to the Director on that day.

A critical incident was submitted to the Director related to resident #004 allegedly abusing resident #005. The DON indicated to Inspector #641 that RPN #112 did not notify her manager at the time, nor did she notify the Director herself. The DON indicated to the Inspector that the Assistant Director of Nursing became aware of this incident the next morning after reading the 24 hour report and the incident was reported to the Director at that time.

The DON indicated to the Inspector that she was aware that these incidents of suspected abuse or neglect had not been reported to the Director immediately. The DON indicated that in each of these incidents, the registered staff, (RN's and RPN's) who had become aware of the incidents, had not followed the Licensee's policy related to immediate reporting of the suspected abuse to either herself during business hours, or to the MOHLTC pager after hours.

Inspector #641 reviewed the licensee's policy for Zero Tolerance of Abuse and Neglect Program, revised date August 25, 2016, and on page 3 it states "All staff must immediately report every alleged, suspected or witnessed incidents of abuse of a resident by anyone." Further, on page 7 of the same policy "all staff, volunteers, contractors and affiliated personnel are required: to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the MOHLTC. … To immediately report to the appropriate supervisor in the home on duty at the time of a witnessed or alleged incident of abuse or neglect." The Inspector reviewed a memo dated April 15, 2017 from the DON to all staff related to the reporting of alleged /suspected abuse stating "Nurses are to report immediately to the DON, (ADON when DON not available) during business hours. Outside business hours, nurses are to call the MOHLTC Pager."

The DON indicated to the Inspector that the Licensee had conducted mandatory education with the staff related to zero tolerance of abuse, which included specific information related to immediate reporting of suspected or alleged abuse or neglect, in December of 2016 and again in May of 2017. DON #104 reviewed with the Inspector that on April 15, 2017 she had placed a memo in the PSW communication books on the units and emailed the registered staff related to immediate reporting of alleged/suspected abuse of any kind. The DON further indicated that in June of 2017, she laminated the MOHLTC Abuse Tree Algorithm outlining the Licensee reporting of suspected abuse or neglect, and placed one at each nursing station and that she had sent emails to the registered staff related to immediate reporting in June.

The licensee has failed to ensure that the Director was immediately notified when the staff had reasonable grounds to suspect abuse of residents #007, #009 and #005. Log #035355-16, Log #007633-17 and Log #011135-17 [s. 24. (1)]

Issued on this 5th day of July, 2017

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

Original report signed by the inspector.