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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2017	2017_589641_0030	019227-17	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

CATHI KERR (641), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 25, 26, 27, 28 and 29, 2017

The purpose of this inspection was to conduct a Resident Quality Inspection. The following critical incident logs were inspected concurrent with the RQI: Log #014136-17 related to alleged staff to resident abuse; Log #017117-17 related to a resident falling resulting in an injury; and Log #014927-17 related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Activation Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the RAI Coordinator, housekeeping Staff, Family Council President, Resident Council President, family members, and residents.
Also during this inspection, the inspectors conducted a tour of the home, observed medication administration and written processes for handling of medication incidents and adverse drug reactions, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident and family council minutes, the home's staffing schedules for the nursing department and policies and procedures related to restraints, falls prevention and the prevention of abuse and neglect.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

2 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 an alleged incident of improper care that resulted in harm of a resident was immediately reported to the Director.

On a specified date, the Director of Nursing (DON) at Hastings Centennial Manor was alerted to an incident of alleged staff to resident abuse by supervising RN # 118 that had occurred that morning. PSW staff # 102 reported both verbally and in a written note that she had witnessed PSW # 101 providing care for resident #023; PSW #101 was observed to be in a rush and "very rough" with the resident. PSW #102 further indicated that resident #023 asked PSW #101 to stop because the resident was being hurt. The DON informed the Director of the alleged abuse the next day after the incident occurred. The ADOC indicated that the home should have informed the Director on the morning that the incident occurred. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 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,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(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. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker (SDM) was notified within 12 hours upon becoming aware of alleged, suspected or witnessed incident of abuse or neglect of the resident.

On a specified date, PSW Staff #101 and #102 answered resident #023's call bell. PSW #102 reported PSW #101 was rough with resident #023 who called out asking PSW#101 to stop because "it hurts". PSW #102 reported the incident to the supervising RN twenty minutes later, who alerted the Director of Nursing (DON) via voice mail that morning. The SDM was not informed of the incident. In an interview on September 28, 2017 the ADOC indicated that the home should have contacted the SDM on the morning of the incident to advise them of the incident and that the DON would be following up with an investigation into the alleged abuse. [s. 97. (1) (b)]

Issued on this 2nd day of October, 2017

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

Original report signed by the inspector.