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
Jan 30, 2018	2018_589641_0003	025182-17, 027399-17, 029195-17, 029503-17, 000260-18, 001175-18	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF HASTINGS
235 Pinnacle Street P.O.Bag 4400 BELLEVILLE ON K8N 3A9

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): January 18, 19, 22, 23, 24 and 25, 2018.

The following logs were inspected during this inspection: critical incidents log #000260-18, #027399-17, #025182-17, #029503-17 related to falls resulting in injury; critical incident log #029195-17 related to an outbreak being declared in the home; and complaint log #001175-18 related to resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the RAI Coordinator and residents.
During the course of the inspection, the Inspector reviewed resident care and services, staff to resident and resident to resident interactions, reviewed resident health records and Critical Incident System reports (CIS) and relevant licensee investigations.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 the resident 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.

A critical incident was submitted to the Director on a specified date, related to resident #001 falling, causing an injury.

Inspector #641 reviewed resident #001's health care records. The assessments indicated that the resident had multiple falls in a specified eight month period. Prior to the first fall during this specified period, resident #001's Falls Risk Assessment Tool (FRAT) indicated that the resident was at low risk for falls. On a specified date, a FRAT assessment was completed indicating that the resident was at high risk for falls. During the specified eight month period, resident #001 had eight FRAT assessments completed indicating that the resident was at high risk for falls. A review of the resident's care plan documented that the resident was at low risk for falls, which had been generated prior to the resident having a fall. The care plan history indicated that falls risk had not been updated since it had be initiated even though there had been a significant change in resident #001's fall risk, from low to high, throughout the specified time period.

During an interview with Inspector #641 on January 19, 2018, the Director of Nursing (DON) indicated that the expectation of the home was that when a resident fell, the registered staff would complete a resident first fall report and a FRAT assessment. The DON indicated that the care plans were updated on an ongoing basis, as the registered staff implemented new interventions. The DON acknowledged that it didn't appear that resident #001's care plan related to falls risk had been updated with either the change of level of risk and or with new interventions.

During an interview with Inspector #641 on January 19, 2018, the RAI Co-ordinator #104 (RAI) clarified that the registered staff were to be updating the care plans whenever they made changes to the residents care. RAI #104 specified that when a FRAT was done on a resident, the results of this would be updated in the resident's care plan as well.

During an interview with Inspector #641 on January 19, 2018, ADON #100 indicated that it was her understanding that the registered staff were to be updating the care plans whenever there was a change in the resident or if there were different interventions put into place. The ADON acknowledged that she was aware that resident #001's care plan

had not been updated to indicate the change in the falls risk from low to high.

The licensee failed to ensure that resident #001's plan of care was reviewed and revised when the resident's care needs changed. [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 the resident is reassessed and the plan of care reviewed and revised at least every six months and 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

A critical incident was submitted to the Director on December 18, 2017 documenting an acute respiratory illness outbreak that occurred in the home starting on December 1, 2017.

During an interview with Inspector #641 on January 24, 2018, the Director of Nursing (DON) indicated that the respiratory outbreak had been declared on December 1, 2017. She specified that she had not been aware that a critical incident was not initiated on the day it was declared. She clarified that she notified the Director on December 18, 2017 when she became aware that a critical incident had not been submitted.

On January 24, 2018, during an interview with the Inspector, the Assistant Director of Nursing (ADON) indicated that she had initiated the report of the respiratory outbreak to the Public Health Department but that she had not been aware that she was required to notify the Director immediately of the disease outbreak.

The licensee failed to ensure that the Director was immediately informed of the acute respiratory outbreak that was declared in the home on December 1, 2017. [s. 107. (1)]

Issued on this 30th day of January, 2018

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

Original report signed by the inspector.