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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2019	2019_779641_0030	018230-19, 019396-19, 019657-19	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): October 11, 15, 16, 17. 2019 onsite and October 18, 2019 offsite.

This inspection was conducted in reference to three critical incidents: Log #019396-19, CIS M537-000031-19 and Log #019657-19, CIS M537-000032-19 related to suspected resident to resident abuse; and Log #018230-19, CIS #M537-000029-19 related to a resident having fallen resulting in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Assistant Director of Nursing, Registered Nurses, Registered Practical Nurses, Personal Support Workers, families and residents. During the course of the inspection, the Inspector observed staff to resident and resident to resident interactions, reviewed resident health care records and Critical Incident System reports (CIS) and reviewed policies and procedures related to zero tolerance of abuse and falls prevention.

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

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	Légende 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 failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

On a specified date, PSW #106 found resident #001 laying on top of resident #002 on the floor beside the bed, with resident #002 naked from the waist down and resident #001's genitals exposed. Resident #002 was assessed and there was no evidence of injury. Resident #002 did not remember the incident.

Critical incident #M537-000031-19 was submitted to the Director on a specified date and time, sixteen hours after the incident occurred.

RN#104 indicated that at the time of the incident on the specified date, the RN had followed the algorithm for sexual abuse and when the RN came to the statement that indicated to call the Director, the RN called the Director of Nursing. When asked by the Inspector about following the algorithm related to physical abuse, the RN stated that had this been an incident where one resident had injured another resident, the RN would have called the Ministry of Long-Term Care immediately, but the RN advised having not remembered what the process was for sexual abuse. The RN specified having completed annual training about abuse but found the terminology in the algorithms very confusing.

The Director or Nursing (DON) indicated that when the Registered Nurse (RN) had called the DON at the time of the incident, the DON had told the RN to report the incident to the Ministry of Long-Term Care, but the RN had not done this. The DON had gone into the home immediately but was not aware at that time that the RN had not reported the incident into the Director.

The Licensee failed to ensure that the RN who had reasonable grounds to suspect an abuse of resident #002 by resident #001 that resulted in a risk of harm did not immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Issued on this 25th day of October, 2019

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

Original report signed by the inspector.