Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Aug 24, 2021	2021_779641_0026	007223-21, 012520-21	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): August 4, 5, 6, 10, 2021.

This inspection was conducted in reference to intake log #007223-21, CIS #M537-000011-21 related to resident to resident alleged abuse and intake log #012520-21, CIS# M537-000017-21 related to a resident sustaining an injury of unknown causes.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Nursing-RN, the Assistant Director of Nursing-RPN, the Environmental Service Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

During this inspection the Inspector completed a tour of the home, observed residents' environments, the provision of care and services to residents, reviewed relevant resident health care records, and policies and procedures related to Zero tolerance of abuse and neglect, Falls Prevention, Infection Prevention and Control, Heat Related Illnesses and Air Conditioning in the Home.

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

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 O.Reg 79/10, s. 21. Air temperature

Findings/Faits saillants :

1. The licensee failed to ensure that the temperature in the home was maintained at a minimum 22 degrees Celsius.

Inspector #641 observed the temperature logs maintained by the licensee for the designated cooling areas, two residents' rooms, and a common area on each unit. It was noted by the Inspector that the temperatures for the month of July documented for the Hybla Sunroom, a designated cooling area, ranged from between 17.0 to 20.0 degrees Celsius. There were multiple temperatures in other areas of the home documented below 22 degrees Celsius. The Inspector spoke with three residents in three separate areas of the home who each indicated that they were cold.

During an interview with Inspector #641, the Environmental Service Manager (ESM), indicated that the temperatures were recorded electronically, through the Building Automated System and were deemed to be accurate. The ESM advised that there was an alert on the system to notify staff if the temperatures were not within the appropriate range. The ESM stated that they had not been receiving any alerts notifying them that the temperatures had been too low. This posed a risk to the residents as the staff were unaware that the temperatures were below 22 degrees Celsius.

Source: Interviews with staff, residents, the Administrator and the Environmental Service Manager; policies and procedures related to heat related illness and air conditioning units; observations of temperatures throughout the home. [s. 21.]

Issued on this 24th day of August, 2021

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

Original report signed by the inspector.