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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 6, 2013	2013_049143_0053	O-000928-13	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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 5th and 6th, 2013.

During the course of the inspection, the inspector(s) spoke with the Site Supervisor, the Director of Nursing, a resident and a Personal Support Worker (PSW).

During the course of the inspection, the inspector(s) reviewed the homes internal abuse investigation report, abuse policies and procedures and a resident health care record.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Ontario Regulation 79/10 made under the Long-Term Care Homes Act, 2007 section 5. states, "Neglect" definition means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Resident #1 plan of care identifies that she/he is at risk for skin breakdown, is incontinent and requires assistance for all activities of daily living.

A review of the nursing progress notes indicated that on specified dates Resident #1 requested a laxative.

On a specified date a family member complained to the Director of Nursing that Resident #1 had requested continence care and was denied care by two PSWs. The complainant indicated that family members had advised staff member (S103) that Resident #1 had soiled her/his brief. On a specified date an internal abuse/neglect investigation immediately commenced. The Ministry of Health and Long Term Care was notified and a Critical Incident Report was submitted on a specified date reporting the alleged abuse/neglect.

Resident #1 reported to the inspector that she/he had advised two Personal Support Workers, staff members (S102 and S103) that she/he was incontinent of stool. Resident #1 reported to the inspector that both PSWs advised her/him that she/he had to wait. Resident #1 reported to the inspector that she/he was incontinent of loose diarrhea. Resident #1 reported that she/he felt a burning/scalding sensation and was extremely uncomfortable until she/he was provided care approximately one to one and half hours later.

S102(PSW) was interviewed by the inspector. S102 reported that on a specified date Resident #1 did request to be changed prior to dinner. S102 reported that he/she advised Resident #1 that he/she was going on his/her break and could not provide assistance at that time. S102 reported to the inspector that he/she advised S103 (PSW) that Resident #1 required continence care and was informed by S103 that Resident #1 would have to wait. S102 reported that approximately one to one and a half hours later continence care was provided and that the resident was in fact incontinent of loose/watery stool.

S102 was questioned about abuse training and indicated that he/she had attended the mandatory annual in-services held February 2013 . Ontario Regulation 79/10 section 5 definition of neglect was presented to S102 to review. S102 was questioned if this was something he/she had learned from abuse training and indicated that it was. S102 was questioned as per the definition of neglect, if care and assistance was not provided to Resident #1 and he/she indicated "yes it would seem so". S103 was not able to be interviewed.

A review of the homes internal abuse investigation indicated that neither S102 or S103 had requested assistance from any other staff to ensure that Resident #1 received care as per his/her request for assistance. Management staff at the home reviewed and implemented the County of Hastings Human Resource Policy #8, Discipline/Warning Procedure.

The licensee has failed to comply with the Long-Term Care Homes Act, 2007 section 3.(1)3. by not ensuring that every resident has the right not to be neglected by staff. [s. 3. (1) 3.]

Issued on this 7th day of November, 2013

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

P Miller