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
Apr 25, 2014	2014_280541_0011	O-000270-14	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

AMBER MOASE (541)

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): April 23, 2014.

During the course of the inspection, the inspector(s) spoke with the Site Manager, the Director of Care(DOC), Personal Support Workers, a Housekeeper and residents.

During the course of the inspection, the inspector(s) reviewed the home's investigation, reviewed the critical incident report, reviewed resident health care records, reviewed the home's in-service education and reviewed policy F-20: Zero Tolerance of Abuse and Neglect Program as well as policy F-20A: Zero Tolerance of Abuse and Neglect - Appendices.

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 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 comply with LTCHA 2007 c.8 s.24(1) whereby they did not ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur immediately reported the suspicion and the information upon which it is based to the Director: 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.

A review of the home's internal investigation notes indicates that on a specified date staff member S103 witnessed staff member S104 call resident #1 a derogatory name. Staff S103 believed that Resident #1 heard this comment. Staff S103 did not immediately inform the Director of the witnessed alleged verbal abuse.

On a date two days after the alleged abuse occurred, the home became aware of the above described incident when staff member S103 reported it to the site manager. The site manager and DOC then asked staff S103 to put his/her concerns in writing and submit to the home. Two days later on a specified date, the home received a written letter from staff S103 describing the incident.

A review of the LTC Home Emergency Pager incident report indicates the Director was first notified of this incident two days after the home became aware of it. The site manager confirmed with Inspector 541 that the home had reasonable grounds to suspect verbal abuse had occurred two days prior to the date the Director was notified. [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 comply with O. Reg 79/10 s. 97(1)(b) whereby they did not ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On a specified date, staff member S103 reported to the site manager that two days prior he/she witnessed staff member S104 call resident #1 a derogatory name. Staff S103 believed that Resident #1 heard this comment.

Resident #1 diagnoses include unspecified dementia. According to his/her most recent Minimum Data Set (MDS) assessment, Resident #1 has both short and long-term memory problems, is not normally able to recall staff names or faces and his/her CPS score is 3/6.

A review of the critical incident report indicates that Resident #1's substitute decision maker(SDM) was not contacted.

On April 23, 2014 during a discussion with Inspector 541 the site manager stated that her expectation would be that the SDM of a family member be notified when there is an alleged incident of verbal abuse. The Director of Care confirmed with Inspector 541 that she did not contact the family member of Resident #1 as Resident #1 denied that the alleged abuse occurred. [s. 97. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 104(1)5 whereby the licensee did not ensure the report to the Director included whether an inspector has been contacted and if so, the date of the contact and the name of the inspector.

A review of the critical incident report submitted by the home on a specified date did not indicate whether an inspector has been contacted and if so, the date of the contact and the name of the inspector.

During an off-site inquiry conducted on a specified date, the DOC stated she notified the Director of an alleged incident of verbal abuse via the after-hours pager on a specified date. A review of the LTC Home Emergency Pager Incident Report indicates the home contacted the after-hours pager two days after becoming aware of the incident of alleged abuse.

The home failed to ensure that the report to the Director included that an inspector was contacted, the date of the contact and the name of the inspector. [s. 104. (1) 5.]

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Issued on this 9th day of May, 2014

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

Amber Moase