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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 24, 2015	2015_348143_0019	O-001593-15, O-001654-15, O-001855-15 & O-001859-15	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

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

This inspection was conducted on the following date(s): April 20th to 24th, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Practical Nurses, Personal Support Workers, residents and a visitor.
The Inspector observed resident care and services, reviewed resident health care records inclusive of plans of care, assessments, physician orders, staff educational attendance records and reviewed policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse.

Ontario Regulation 79/10 abuse definition states the following:
2. (1) For the purpose of the definition of "abuse" section 2. (1) of the Act,
"emotional abuse" means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other then a resident,
"verbal abuse" means,
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident,

On a specified date a Personal Support Worker (PSW) S100 assisted Resident #2. Resident #2 reported to another PSW S101 that S100 had been rough with her\him and that she\he had been verbally abusive towards her\him. The home completed an internal abuse investigation and concluded that S100 had abused Resident #2.
Resident #2 was interviewed by Inspector #143 and reported the following;
"A PSW (S100) was assisting me in the bathroom. When I went to stand up the PSW yanked on my pants so hard that I almost fell over". Resident #2 reported that she\he grabbed the handrail at the side of the toilet to prevent herself\himself from falling over. The resident reported that the staff member stated to her\him that "she\he wasn't the only resident that she\he had to care for". The resident reported to the inspector that she\he did not sustain any injuries and was not in any pain.
On April 22nd 2015 the Administrator and Director of Care (DOC) reviewed the incident of abuse with the inspector. The DOC indicated to the inspector that the verbal comment made by S100 was of a degrading nature and that the care provide by S100 met the definition of emotional abuse as the actions taken by S100 was of a threatening nature as the resident could have fallen.
A review of the homes internal investigation report confirmed what the resident had reported to the inspector.

Resident #4 had an annual care conference. At this care conference it was brought to the attention of staff at the home that on a specified date a visitor had overheard a PSW verbally abuse Resident #4. Administrative staff at the home began an internal investigation and submitted a Critical Incident to the Ministry of Health and Long Term Care. The home's internal investigation concluded that S104 had verbally abused the resident.
On April 23rd, 2015 Inspector #143 interviewed S104. S104 reported to the inspector that in response to the residents request to be toileted "three times in less then half an

hour" that "I lost it". S104 reported that she\he was frustrated and that she\he had directed her\his frustration at the resident's visitor. On a specified date the visitor was interviewed by telephone. This visitor reported to the inspector that she\he had overheard S104 speaking in a loud and angry tone to the resident behind a closed bathroom door. The visitor stated that she\he had asked S104 why she\he had spoken to the resident in such a manner and reported that S104 provided no response. The visitor was asked how the resident reacted to being treated this way and she\he reported that the resident appeared upset and stated "I don't know why she\he has to speak to me like that". The visitor reported to the inspector that S104 had presented as being upset, rude and had used an angry tone while speaking to the resident. [s. 19. (1)]

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 all residents are protected from emotional and verbal abuse and that all staff attend annual abuse training, to be implemented voluntarily.

Issued on this 6th day of May, 2015

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

Original report signed by the inspector.