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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 23, 2015	2015_396103_0008	O-001158-14, O-001501-15	Complaint

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 MANOR HOME FOR THE AGED
476 DUNDAS STREET WEST P.O. BOX 458 BELLEVILLE ON K8N 5B2

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 15, 16, 19, 20, 21 and 22, 2015.

The following logs were included in this inspection: O-000625-14 and O-001158-14.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers, Registered Practical Nurses, Registered Nurses, the Administrative Assistant, the Director of Nursing, the Site Manager and the Administrator.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **5 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 O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10, s. 129 (1) (a) whereby medications were not secured and locked in an area or a medication cart.

During an interview with Resident #1's Power of Attorneys (POA's), this inspector was advised that on an identified date, medications were found in the hallway on the shelf outside of the resident's room. The POA stated the medications were brought to the attention of RPN S#108 who removed the medications and stated they must have been left there by the day medication nurse. S#108 was interviewed and confirmed the medications were not Resident #1's and was unable to determine the resident for whom the medications were intended.

According to S#108, the medications were removed, this incident was not reported and no further action was taken.

This inspector also spoke with RN S#109 who confirmed she had heard medications were found on the shelf outside of Resident #1's room and were removed by a staff member. The staff member had no further knowledge of any additional actions taken.

The DON was interviewed and stated there had been no evidence to support the allegations that medications were left outside of Resident #1's room. The DON was provided with the above information and stated she would further follow up on the incident.

The Administrator stated medication errors are taken seriously and are a means of improving the medication delivery system. She stated the home would follow up on this incident and the home is initiating an on-line medication refresher course that all registered staff will be required to complete. [s. 129. (1) (a)]

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 all medications are secured and locked in an area or a medication cart when not being administered to a resident, to be implemented voluntarily.

WN #2: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, 2007, s. 3 (1) 1 whereby the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident was not promoted.

Resident #1 is a cognitively well resident and is independent in decision making. During a review of the resident's progress notes, an entry was noted on an identified date which described a PSW entering through the closed door to Resident #1's room without knocking. The PSW found the resident on the toilet in the bathroom and proceeded to offer the resident a drink from the snack cart. At the same time, a housekeeper entered through the closed door of the bathroom from the adjacent resident's room. Resident #1 described feeling embarrassed and raised their voice to the staff members advising them of the right to privacy and respect.

RN S#103 was interviewed and recalled the incident. She concurred that under no circumstance should any staff member enter through a closed resident door without knocking and awaiting a response. The RN stated she counselled the staff following the incident.

During an interview with Resident #1, a large sign was posted on the resident door upon the direction of the resident. The sign stated "DO NOT DISTURB". During the time that this inspector was present in the resident room, a staff member knocked on the door despite the signage.

Resident #1 was visibly upset by the intrusion and stated staff do not respect the right to privacy. The resident went on to say they recently had been feeling unwell and could just have easily been attempting to get some rest.

The Administrator was interviewed and stated it would be her expectation that all staff would respect the resident's wishes to not be disturbed as indicated by the posted signage. [s. 3. (1) 1.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 22 (1) whereby a written letter of complaint received by the home concerning the care of a resident or the operation of the home was not forwarded to the Director (MOHLTC).

On an identified date, a written complaint was received by the home, outlining concerns related to Resident #1, including allegations of verbal abuse and care related issues. To date of this inspection, this letter was not forwarded to the MOHLTC. [s. 22. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10 s. 101 (2) whereby written complaints were not included in the home's documented record of complaints.

The home received written complaints on two separate identified dates regarding Resident #1. The first complaint outlined allegations of verbal abuse and care related concerns. The second complaint letter outlined issues related to safe medication administration. The home's complaint log was reviewed and did not include either of the written complaints.

The Administrative Assistant confirmed neither of the written complaints were included in the home's documented record of complaints to date of this inspection. [s. 101. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Regs 79/10 s. 135 (2) whereby all medication incidents are not documented.

On an identified date, medications were found on the small shelf outside of Resident #1's room. In an interview with S#108, she stated she found the pills on her evening shift, were aware they were not Resident#1's medications and believed the medications had been left from the day staff. S#108 stated she was unable to determine whose medications they were.

In an interview with the DON, she stated she was not aware of any pills being found outside of Resident #1's room at any time and therefore, no medication incident report had been completed. [s. 135. (2)]

Issued on this 26th day of January, 2015

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

Original report signed by the inspector.