



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 10, 2015	2015_270531_0022	O-002428-15/O-002483 -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

SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

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

This inspection was conducted on the following date(s): August 11, 12, 13 and 14, 2015

During the course of the inspection, the inspector(s) spoke with Residents, Residents families, Personal Support Workers, Registered Practical Nurses, Registered Nurses, the Assistant Director of Care, the Acting Director of Care and the Administrator.

During the course of the inspection the inspector observed resident care and services, reviewed resident health care records and reviewed complaints log and documentation and policies and procedures.

The following Inspection Protocols were used during this inspection:

Medication

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

2 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised, (a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).



Findings/Faits saillants :

1. The licensee has failed to comply with the LTCH Act 2007, c. 8, s 6 (11) whereby different approaches were not considered when care set out for a particular resident with behavioural symptoms was not effective.

Reference to Log# O-002428-15 Complaint

Resident #2's diagnoses include COPD and dementia.

Upon review of Resident #2's health record it was noted that Resident #2 has a history of behavioural symptoms.

Review of Resident #2's progress notes indicate that the interventions set out in the care plan were not effective.

Resident #2's care plan was reviewed for the several months. Resident #2 was assessed as having behavioural symptoms.

Written strategies for managing Resident #2's behavioural symptoms include the following:

- distract resident if can not be distracted leave and re approach
- allow for flexibility in ADL routine
- re direct
- document care being resisted
- if refuses care leave and return in 15 minutes

During an interview with PSWs S101,S102 and S103 noted that Resident #2's behavioural symptoms have increased steadily since admission and that the interventions in place have not been effective.

During an interview on August 13, 2015, RPN S104 confirmed that Resident #2 has shown behavioural symptoms, such as resistance to care, since admission and acknowledged that these symptoms had worsened in the past year. RPN S104 indicated that the best intervention is to re approach residents with behavioural symptoms and although there have been adjustments to Resident #2's treatments no other approaches have been considered.

On August 13, 2015 during an interview with RN S106, the ADOC and the Acting



Director of Care confirmed that the behavioural symptoms have escalated and that the interventions have not been effective. [s. 6. (11) (b)]

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 when a resident is reassessed and the plan of care reviewed and revised for residents with behavioural symptoms is not effective different approaches are considered., to be implemented voluntarily.

WN #2: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

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. Reg. 79/10, s. 101(1) whereby a written resolution or response was not provided with respect to care of a particular resident with responsive behaviours within 10 days of receiving the complaint.

Log # O-002428-15

On a particular date the licensee received a verbal complaint regarding the care of Resident #2 with respect to an increase in behavioural symptoms.

During an interview on August 13, 2015 RN S106 told the inspector that both she and the ADOC investigated the complaint concerning the care of Resident #2 but did not contact Resident #2's Substitute Decision Maker to provide a resolution or response within 10 business days.

On August 13, 2015 during an interview with the Administrator , the Acting Director of Care and the Assistant Director of Care and review of the the Complaint log it was confirmed that a resolution or response was not provided within 10 business days. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home which described the complaint, actions taken time frame for actions and any follow up provided regarding a particular resident with behavioural symptoms.

Reference to Log # O-002428-15

On an identified date the home received a verbal complaint regarding Resident #2's increased behavioural symptoms and care.

On August 13, 2015 during an interview with the Administrator and review of the complainant log documentation confirmed that there was no written record of the complaint with respect to Resident #2. [s. 101. (2)]



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 10th day of September, 2015

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

Original report signed by the inspector.