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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## 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 |
|---|---|---|---|
| Oct 7, 2016 | 2016_505103_0038 | 017540-16, 017728-16, 018997-16, 019176-16, 019851-16, 020840-16, 021224-16, 021547-16, 022203-16, 023188-16, 023475-16, 023922-16, 025803-16, 025824-16, 025831-16 | 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 MANOR HOME FOR THE AGED
476 DUNDAS STREET WEST P.O. BOX458 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 Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 26-30, 2016**

**The following intakes were included in this inspection: 017540-16 (alleged staff to resident neglect), 017728-16 (alleged staff to resident neglect), 018997-16 (alleged staff to resident neglect), 019176-16 (alleged staff to resident neglect), 019851-16 (resident fall), 020840-16 (alleged resident to resident abuse), 021224-16 (alleged resident to resident abuse), 021547-16 (alleged resident to resident abuse), 022203-16 (alleged staff to resident neglect), 023188-16 (resident fall), 023475-16 (alleged staff to resident neglect), 023922-16 (alleged staff to resident neglect), 025803-16 (alleged staff to resident neglect), 025824-16 (alleged staff to resident neglect), 025831-16 (alleged resident to resident abuse).**

**During the course of the inspection, the inspector(s) spoke with residents, Personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Physiotherapist, the Assistant Director of Care, the Director of Care, and the Administrator.**

**During the inspection, the inspector observed resident care, made resident observations, and reviewed resident health care records, the home's fall prevention program and Transfer and Lift policy.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**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)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The following finding relates to Log #022203-16:

The licensee has failed to ensure that the care provided to resident #007 was provided as specified in the plan.

The home submitted an incident report indicating, on an identified date, staff prepared resident #007 for bed and upon leaving the resident room, failed to provide the resident with the call bell within reach. The resident reported they could see the call bell in the chair which was out of reach. At the time of this incident, the resident's plan of care indicated staff were not to check on the resident during the night in accordance with the resident's request. The resident was found by staff to be distraught in the morning and reported having slept poorly as they were worried they would be unable to elicit staff assistance if required overnight.

The resident's care plan in place at the time of the incident indicated:

-call bell to be in reach at all times. [s. 6. (7)]

2. The following finding relates to Log #018997-16:

The licensee has failed to ensure that the care provided to resident #019 was provided as specified in the plan.

Resident #019 was assessed as at risk for falls related to an unsteady gait and unsafe self transfers to the bathroom. On an identified date, the resident was found lying on the floor in the bathroom and sustained injuries as a result of the fall.

The resident's care plan in effect at the time of this fall indicated the following:

-Bedpad alarm in place when in bed.
-Place a floor mat beside bed when in the bed, and tensor elbow pads on both elbows to reduce chance of injury if resident climbs/falls out of bed.
-Wears hip protectors to reduce chance of injury if resident climbs or falls out of bed or wheelchair.
-Uses a clip alarm as a reminder re: need to ask/wait for staff assistance. Staff to respond as quickly as possible when alarm sounds.

Following the fall, the registered staff noted the resident was not wearing hip protectors, and the bed alarm was turned off. The home interviewed the PSWs who stated the resident's hip protectors were being laundered and therefore could not be applied. Neither PSWs recalled checking the bed alarm to ensure it was on after settling the resident to bed.

The DOC was interviewed and indicated it is an expectation that all staff ensure all fall prevention measures are in place and working as outlined in the resident plan of care. She indicated all PSW's involved were counselled following the incidents. [s. 6. (7)]

***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 resident #007 and #019's fall prevention interventions are in place in accordance with the resident's plans of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The following finding relates to Log #019851-16:

The licensee has failed to ensure that safe transferring techniques were used when assisting resident #005.

On an identified date, two staff were transferring resident #005 from the bed to the wheelchair using a mechanical lift. During the transfer, the left clip on the transfer sling detached from the lift and the resident fell to the floor. The resident was assessed for injuries and transferred to hospital.

The home conducted an investigation into the incident and determined the left clip on the sling had not been firmly secured by the staff prior to the transfer. The plastic clip was observed to have a short woven strap located above the clip and this was believed to have become lodged in such a way that it prevented a secure attachment to the mechanical lift.

The ADOC was interviewed and indicated they determined the incident occurred due to staff error. She stated one staff member is responsible for ensuring the sling is attached correctly to the mechanical lift prior to the lift/transfer, and this is also reflected in the home's Transfer and Lift policy, #H-265.

Following the investigation, the home re-educated all front line staff on the potential hazards related to the placement of the woven strap during resident transfers. Additionally, resident #005's plan of care was changed such that three staff members would now be required for all transfers. [s. 36.]

***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 safe transferring techniques are utilized when transferring resident #005, to be implemented voluntarily.***

**Issued on this 11th day of October, 2016**

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

**Original report signed by the inspector.**