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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2017	2017_520622_0035	022456-17	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

HEATH HEFFERNAN (622)

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): October 5, 10, 11, 12, 13, 2017

Log#022456-17 for a complaint related to an identified resident fall causing injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Nursing (ADON), a Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the complainant.

Also during the course of the inspection, the inspector reviewed resident health records, related critical incidents and the nursing homes applicable complaint investigation notes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The following non-compliance is related to Log #0022456-17

The licensee has failed to ensure that the plan of care related to transfers for resident #002 set out clear directions to staff and others who provide care to the resident.

During an interview on an identified date in October 2017, the complainant indicated that based on resident #002's abilities, he/she required two persons for all transfers. The complainant indicated that he/she had asked for a copy of the home's incident report and had received two copies approximately one week a part. The complainant indicated he/she had noted a discrepancy in the two incident reports related to the number of attendants with resident #002 when he/she fell. The complainant indicated he/she believed the plan of care was not being followed at the time of the fall.

During interviews on two identified dates in October 2017 with ADON #102, she indicated resident #002 required two staff for transfers and the logo board had been updated. ADON #102 indicated there would not be permanent copies of the logo board on record however any addition to the logo board would have been documented on the progress notes, care plan and Kardex.

A review of the latest care plan dated a specified date and Kardex dated a specified date did not indicate that resident #002 required two staff for transfers when the logo board did.

During separate interviews on an identified date in October 2017 with inspector #622, both the ADON #102 and the Administrator reviewed the Care Plan and Kardex for resident #002. Both the ADON #102 and the Administrator indicated neither the care plan nor Kardex had been updated to include two persons for all transfers. Furthermore the Administrator indicated if the logo board indicated resident #002 was two staff for transfers and the care plan indicated something else, this would not be providing clear direction for staff giving care.

Therefore the licensee had failed to ensure that the plan of care related to transfers for resident #002 set out clear directions to staff and others who provided care to the resident. [s. 6. (1) (c)]

2. The following non-compliance is related to Log #0022456-17

The licensee has failed to ensure that the plan of care related to toileting for resident #002 set out clear directions to staff and others who provide care to the resident.

During an interview on an identified date in October 2017, the complainant indicated that resident #002 had declined in condition. The complainant also indicated he/she thought resident #002 received care at the bedside and should not have been toileted. The complainant indicated that based on resident #002's abilities, he/she required two persons for all transfers including toileting and indicated he/she believed staff had not used the two staff required to assist resident #002 in the washroom the night of his/her fall on the specified date.

A review of the most recent care plan and Kardex indicated neither of the documents had been updated to provide the direction for the two staff required to toilet resident #002.

During an Interview with inspector #622 on an identified date in October 2017, RPN #103 indicated resident #002 required two staff for toileting. RPN #103 indicated staff had used the two staff to toilet resident #002 on the specified date when the resident had his/her fall. RPN #103 indicated staff would find the direction for toileting in the care plan, Kardex and the logo board above the bed. RPN #103 indicated the documentation on the logo board, Kardex and the care plan should be updated at the same time otherwise could be confusing to the staff.

During an interview with inspector #622 on an identified date in October 2017, ADON #102 indicated resident #002 had a recent physical decline and as a result required two staff for toileting. ADON #102 indicated for direction related to resident care, staff would refer to the logo board, the care plan and the Kardex. ADON #102 also indicated resident #002's care plan and Kardex did not indicate that the resident required two staff for toileting and furthermore the care plan and Kardex should have been updated.

Therefore the licensee had failed to ensure that the plan of care related to toileting for resident #002 set out clear directions to staff and others who provided care to the resident. [s. 6. (1) (c)]

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 the plan of care related to transfers and toileting for resident #002 set out clear directions to staff and others who provide care to the resident, to be implemented voluntarily.

Issued on this 27th day of October, 2017

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

Original report signed by the inspector.