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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 23, 2019	2019_717531_0006	000159-19, 000292-19, 001157-19, 001221-19, 003900-19, 005919-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Hastings
235 Pinnacle Street P.O.Bag 4400 BELLEVILLE ON K8N 3A9

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

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

This inspection was conducted on the following date(s): March 11, 12, 13, 14, 15 and 18, 2019.

Log #000159-19 Critical incident #M538-000046-18 related to fall prevention
Log #000292-19 Critical incident #M538-000001-19 related to fall prevention
Log #001221-19 Critical incident #M538-000003-19 related to fall prevention
Log #003900-19 Critical incident #M538-000009-19 related to an unexpected death
Log #001157-19, Critical incident #M538-000002-19 related to alleged physical abuse
Log #005919-19 Critical incident #M538-000011-19 related to alleged resident to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing Care (DOC), the Assistant Directors of Nursing (ADON), Registered Nurses (RN), Registered Practical Nurses (RPN), Housekeeping Aide (HKP), Resident Substitute Decision Makers (SDM) and residents.
During the course of the inspection the inspector conducted a walking tour of the home, reviewed resident health care records, observed resident care and services, reviewed internal investigative documentation, reviewed fall prevention policy and procedures, reviewed manufactures instructions for equipment, and reviewed abuse and neglect policy and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that were the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, that the policy was complied with.

Review of Policy #H-265 Transfer and Lift policy reads as follows
Responsibility: All nursing staff.
Only staff who have received training in resident transfer and lifts may move residents in this manner.
Staff should operate a mechanical lift only after receiving instruction in correct usage.
All resident lifts are to be performed by two or more staff including mechanical lifts

Procedure : Mechanical /Ceiling lifts/Bath chair
-one staff are responsible to ensure transfer attached correctly
-one staff is responsible to be a spotter
-two staff must be present when using any lift with resident
-students are not allowed to assist staff with transfer and lifts.

Review of resident #004's plan of care for a specified date indicated that the resident required the assistance of two staff members using the Sara lift only.

During an interview with the DOC, and review of the CIS report, internal investigation documentation and the transfer and lift policy, the DOC indicated that the licensee transfer and lift policy was not complied with as the second person assisting PSW #114 was a student not a staff member.
PSW #114 and RN #115 were unavailable for an interview as they are no longer employed by home.

The licensee failed to ensure that the transfer and lift policy was complied with. [s. 8. (1) (a),s. 8. (1) (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 were the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, that the policy was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with the manufactures' instructions.

Critical incident #M538-000003-19, submitted to the Director, indicated that on a specified date, resident #004 was being transferred using the Sara 3000, sit to stand transfer lift, the resident released their hold on the hand grips and fell from the lift onto their buttocks. The resident did not sustain injuries.
During the post fall assessment it was noted that PSW #114 had not secured the velcro chest strap before engaging the lift as per the manufactures instructions.

Review of the Manufactures Instructions for Use Manual:
Page 10 instructions reads as follows:
To fasten the support strap securely, press the velcro together, remember to tighten the strap once the resident becomes raised from the chair. The support strap will help to support the resident during the raising procedure.
Warning: The chest support strap must always be applied and fastened when used to transfer.
The resident must hold on to the resident support grips with one or both hands. The resident is then ready to be raised.

On March 18, 2019 during an interview with the DOC, and review of the CIS report and internal investigative notes the DOC indicated that the chest support strap had not been secured before engaging the lift in accordance with the manufactures instructions.
The licensee failed to ensure that staff used the Sara 3000 sit to stand lift in accordance with the manufactures instructions. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with the manufactures instructions, to be implemented voluntarily.

Issued on this 29th day of March, 2019

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

Original report signed by the inspector.