Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 20, 21, 23, 2012	2012_038197_0034	Critical Incident

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Director of Long Term Care Services, the Director of Nursing, the Assistant Director of Nursing, the Site Manager, Registered Practical Nurses, a Personal Support Worker and a resident.

During the course of the inspection, the inspector(s) reviewed the home's policy related to abuse and neglect, a critical incident report, the home's internal investigation file, a health care record and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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 licensee has failed to comply with LTCHA 2007, s. 6 (7) in that the care set out in the plan of care was not provided to a resident as specified in the plan.

The current plan of care for resident #1 states the following in relation to toileting and continence care:
- will ask for and receive the necessary assistance
- will ring call bell for assistance to toilet as necessary
- two person assistance to transfer on and off toilet

On the night shift of a specified date, resident #1 asked staff member #S100 several times for assistance to the bathroom.

Staff member #S100 reportedly told resident #1 that he/she could either use a bedpan or void in his/her incontinent product.

Resident #1 went on to ring the call bell eleven times during this night shift and was never assisted to the bathroom.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 24 (1) in that the Director was not immediately notified upon becoming aware of an incident of staff to resident neglect.

On the night shift of a specified date it was reported to a Registered Practical Nurse that a Personal Support Worker had refused to assist a resident to the bathroom.

This incident was reported to the Director of Nursing two days later.

A Critical Incident Report was submitted to the Director (Ministry of Health and Long-Term Care) six days after the incident occurred.

Issued on this 23rd day of November, 2012

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

Jessica Pattison, RD