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

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 17, 2015	2015_396103_0042	O-001702-15	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. BOX 458 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): June 23, 24, 26 and 29, 2015

The following logs were included in this inspection: O-001702-15, O-002053-15, O-002060-15, O-002096-15, O-002164-15, O-002181-15, O-002339-15 and O-002341-15.

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

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The following findings relate to Log# O-002181-15:

The licensee has failed to ensure that drugs were administered to Resident #10 in accordance with the directions for use specified by the prescriber.

Resident #10 has identified diagnoses and is prescribed Fentanyl patches to be applied every seventy-two hours for pain management and Dilaudid 2mg by mouth every two hours as required for breakthrough pain.

On an identified date, staff noted that Resident #10 was exhibiting signs and symptoms of medication withdrawal and also noted an increase in the use of Resident #10's breakthrough medication on two identified dates. The Fentanyl patch had last been applied on an identified date but was not in place two days later. A new Fentanyl patch was applied at that time and the resident continued to receive breakthrough medication until the pain was well managed.

The Administrator was interviewed and stated at the time of this incident, the staff were not required to check the Fentanyl patches on a regular basis to ensure they remained in place between the scheduled applications. Since the incident, the staff are now required to check the patch each shift. According to the Administrator, the registered staff will be receiving education related to medication administration in the near future and that Fentanyl patches will be included in the education.

The home failed to ensure Resident #10 received the prescribed Fentanyl patches for pain management in accordance with the directions for use by the prescriber. [s. 131. (2)]

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 #10's drugs are administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The following findings relate to Log# O-002341-15:

The licensee has failed to ensure that the home's abuse policy was complied with.

Resident #9 is a cognitively well resident that was admitted to the home in 2011. On an identified date, the resident requested to receive a dinner tray in their room as they were feeling unwell. A PSW refused to bring the resident a tray and told the resident they needed to go to the dining room. The following day, Resident #9 reported to RPN S#110 that they felt the PSW had been rude.

RPN S#110 failed to report the incident until three days later when she disclosed the information to the Administrator. The Administrator stated S#110 believed the incident was neglectful and the staff member stated she knew it should have been reported immediately and had just recently completed the annual prevention of abuse training. The Administrator investigated the incident, determined another PSW had provided a tray to Resident #9 that evening and there had been no negative outcome to the resident.

The home's zero abuse policy, F-20/F-20A, "Zero Tolerance of Abuse and Neglect Program and Appendices", states under "LTCHA Mandatory Reports", In accordance with LTCHA, s. 24 (1), a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the MOHLTC.

S#110 failed to immediately report her suspicion that the PSW had been neglectful in not providing Resident #9 a tray and did not follow the home's abuse policy in regards to

reporting. [s. 20. (1)]

2. The following findings relate to Log# O-002053-15:

On an identified date, S#108 was working with S#105 and providing care to Resident #7. During the provision of care, S#108 believed that S#105 had pulled the resident's hair in retaliation of behaviours displayed by the resident. S#108 failed to report the allegation of resident abuse until the next day when she advised the Director of Care (DOC). According to the Administrator, the staff member had recently completed abuse training which contains information related to mandatory reporting.

The staff member failed to follow the home's abuse policy by not immediately reporting the allegation of abuse. At the time of this incident, the home was still under a compliance order that had been issued under the LTCHA, 2007, s. 19 with a compliance date of April 30. [s. 20. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The following findings are related to Log# O-002339-15:

The licensee has failed to ensure a care conference of the interdisciplinary team providing a resident's care was held within six weeks following Resident #1's admission.

Resident #1 was admitted to the home on an identified date. The six week care conference was not completed until approximately eleven weeks after the resident's admission. [s. 27. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The following findings relate to Log# O-002164-15:

The licensee has failed to comply with O. Regs 79/10 s. 30 (2) whereby an assessment and interventions related to a resident injury was not documented.

Resident #8 has identified diagnoses and on the evening of an identified date, Resident #8 was observed by PSW staff to have a potential identified injury. They reported this to RPN S#107 who assessed the resident and then asked RN S#109 to assess the resident for injuries.

RN S#109 was interviewed and stated she did recall being asked to assess Resident #8 but was unsure of the details related to her assessment or to any interventions that she may have suggested. The RN was asked if she had documented her assessment and stated if she had it would be in the resident progress notes. The RN further stated that sometimes the RPN will document the assessment on the RN's behalf. The resident's health care record was reviewed and there was no documented assessment found to reflect the RN's assessment of Resident #8's injuries.

The following morning, Resident #8 was assessed by RN S#106 and was sent to hospital and later diagnosed with an identified injury. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The following findings relate to Log# O-002060-15:

The licensee has failed to ensure that in making a report to the Director under s. 23 (2) of the Act, a description of the individuals involved in the incident will include the names of any staff members who were present at or discovered the incident.

On an identified date, the home submitted a critical incident report (CIS) in regards to an allegation of staff to resident abuse. The CIS failed to identify the staff member who was alleged to have been abusive toward the identified resident. [s. 104. (1) 2.]

Issued on this 17th day of July, 2015

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

Original report signed by the inspector.