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

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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
Jan 20, 2016	2016_389601_0001	030089-15	Resident Quality Inspection

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

KARYN WOOD (601), DARLENE MURPHY (103), HEATH HEFFERNAN (622), JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 2016.

The following logs were inspected during this inspection:

Complaint Log (s) #004780-15, #024863-15, and #000629-16.

Critical Incident Log(s): #016248-15, #022028-15, #022967-15, #024046-15, #026447-15, #028942-15, #031116-15, #025561-15 and #034064-15.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of the Resident Council, President of the Family Council, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide, Registered Dietitian (RD), Food Service Manager, Laundry Aide, Environmental Service Manager, Activation Aide, Assistant Director of Nursing, Director of Nursing, and the Administrator.

Also completed during the inspection, an initial walk through tour of all resident care units, observed resident dining, resident activities, and observed resident care, medication administration including medication storage areas, reviewed resident health care records and licensee policies related to various practices in the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **7 WN(s)**
- **4 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 licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

During observation on an identified date, Inspector #622 noted the communication safety board in resident #038's room identified two methods of transfer. One transfer logo for resident #038 indicated a one person transfer and the second transfer logo indicated the need for a mechanical stand lift.

Upon review, the care plan on Point Click Care (PCC) and in the Personal Support Binder both stated for resident #038:
-Continence management requires two person constant supervision and extensive assist for safety. May need stand up lift when tired.
-Transferring requires two person constant supervision and physical assist with mechanical stand up or two person side by side.

On an identified date and time, Inspector #622 interviewed PSW #109 who revealed that one staff provides continence assistance for resident #038. PSW #109 indicated that a couple of months ago resident #038 required two staff for assistance, but resident #038's continent needs have changed and is currently able to walk independently. PSW #109 stated staff provide continence assistance for resident #038 alone without assistance from a second staff member.

On an identified date and time, Inspector #622 interviewed RPN #110 who revealed that resident #038 can maintain continence independently. However, resident #038's abilities fluctuate from day to day, one day resident #038 can maintain continence independently and other days requires assistance from staff. RPN #110 stated the resident requires direction to the washroom more now due to resident #038's changing condition. RPN #110 confirmed resident #038's care plan directs two persons extensive assist, and may need the stand-up lift.

On an identified date and time, Inspector #622 interviewed PSW #118 and RPN #117 who indicated resident #038 receives continence assistance by one staff. RPN #117 and PSW #118 reported that staff members follow the care plan, point of care, the communication safety board above the resident's bed for direction on resident care for continence assistance and transfers. RPN #117 confirmed the information should all match.

Interview with the Assistant Director of Nursing (ADON) confirmed the documentation on resident #038's care plan and the communication safety board should reflect the resident current transfer and continence assistance required to provide clear direction to staff. [s. 6. (1) (c)]

2. Related to a critical incident log #024046:

The licensee has failed to ensure that the plan of care for resident #020 set out clear directions to staff and others who provide direct care to the resident related to safety devices.

Resident #020 has been identified as a high risk for falls related to history of falls and sustaining an injury following a fall.

On an identified date ten days following a fall that resulted in an injury, RPN #127 created the care plan intervention for resident #020 to have safety devices in place related to the resident #020's risk for falls.

On an identified date and time, resident #020's progress notes indicated that resident #020 was found lying on the floor next to the bed and had sustained a minor injury. RPN #136 documented that resident #020's safety devices were not in place at the time resident #020 was found on the floor as specified by RPN #127 in resident #020's care plan twelve days prior.

According to the identified critical incident and an interview, the Director of Nursing (DON) indicated that resident #020's safety devices were not in place prior to resident #020 falling out of bed on the identified date and time and the communication safety board in resident #020's room had not been updated to reflect the safety devices required as identified in resident #020's care plan on an identified date by RPN #127. The DON indicated that the safety board in resident #020's room is used to communicate safety devices required and should have been updated by RPN #127 twelve days prior to the fall to provide clear directions to the PSW's to ensure the safety devices were in place for resident #020 as specified in the care plan. [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 for resident #038 has clear direction related to assistance required for transferring and continence assistance. The written plan of correction for achieving compliance for resident #020 to ensure the plan of care set out clear direction related to safety devices as part of the falls prevention, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 69 in that actions were not taken when specified weight changes occurred.

Resident #025 was admitted on an identified date at an identified weight. Resident was assessed at low nutritional risk.

On an identified date and time, resident #025's weight two months following admission date was documented with a weight loss of 6.9 kg, a 13.9 % loss of body weight over one month.

On an identified date, twenty-five days after the weight was taken the Registered Dietitian (RD) #129 made a note that the weight loss of of 6.9 kg was struck out as

incorrect, that intake is good and requested another weight.

Upon review of the resident's weight history, it was noted that the weight loss of 6.9 kg was not struck out and a re-weight did not occur until the next monthly weight.

On an identified date, three months following admission resident #025's weight loss was documented as 5.6 kg (a 10.7% loss of body weight over 3 months). The Resident Assessment Protocol for Nutritional Status dated for the same month by the Registered Dietitian #129 indicated the weight loss noted above, states that the resident's current BMI is an identified number and that the resident's spouse indicated that resident #025's intake was poor prior to and on admission. The assessment goes on to say that the resident is at low nutritional risk and that the goal is to maintain intake above 75% and to maintain weight. There was no action taken at this time to prevent further weight loss.

On an identified date, approximately four months following admission resident #025's weight loss was documented as 5.1 kg (a 10.5 % weight loss over three months). Registered Dietitian #129 documented five days after the residents weight was taken that the resident had lost 10% of body weight, but that weight had been stable over the past 3 months. Resident's intake was noted to be 87% and goal was to maintain intake above 75% of meals.

On an identified date, approximately four and a half months following resident #025's admission, RD #115 documented that an email was received from registered staff related to recent health issues. The note indicated that the resident fell during the same month and sustained an injury. It also indicated that the resident's food intake is at 69% - below the set goal of 75%. This note made no mention of the resident's recent weight loss and no actions were taken.

On an identified date, approximately five months following admission, resident #025's weight loss was documented as 7.4 kg (a 14.2 % weight loss over 6 months).

On the following day, Registered Dietitian #115 documented in the resident's progress notes that an email had been received from staff related to health status. Food intake at this time was noted to be 73%, below the goal of 75%. This note made no mention of the resident's weight loss and again, no action was taken to prevent further weight loss.

Approximately five and half months following resident #025's admission, resident #025's spouse was interviewed by Inspector #197. Resident's spouse indicated no concerns

about the resident losing weight, but was surprised when made aware resident #025 had lost 10.2 kg (22.5 lbs) since admission. Resident's spouse indicated that the resident is a fussy eater and that staff had mentioned the low food intake, but not weight loss.

On two identified dates, a Registered Nurse and three Personal Support workers who work full-time days on the resident's unit were interviewed. Three out of four staff, including the RN, indicated that they were not aware the resident had lost a significant amount of weight, but did state the resident's food intake has been low. The RN #121, looked at the resident's health care record and indicated an email would be sent to the Registered Dietitian to come assess the resident related to weight loss.

On the following day, the Registered Dietitian #129 was interviewed. RD #129 indicated being responsible for the unit where the resident resides and RPN #121 had not emailed RD #129 regarding resident #025 and the weight loss identified. After reviewing the resident's weight history since admission, RD #129 indicated a nutritional assessment of resident #025 would be completed on the same day and a nutritional intervention would be put into place to help prevent further weight loss.

On an identified date, the Director of Nursing (DON) was interviewed and the weight loss history of resident #025 discussed. The DON confirmed that the expectation would have been for action to be taken to prevent further weight loss prior to it being brought to the attention of staff by the inspector. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 action is taken for resident #025 when weight changes occur, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in a medication cart that was not secured and locked.

On an identified date and at 1025 hours, this inspector observed the medication cart of an identified unit to be in the resident hallway outside of an identified room. The inspector observed the medication cart that contained the medications for the residents on this unit unlocked. The inspector remained in the hallway and observed RPN #101 exiting from behind the closed door of the identified room at 1035hr. The RPN was then observed to leave the unlocked medication cart and went to administer medications to the resident in another identified room at 1038hr. The door was partially closed and the medication cart was not visible while the nurse was in the room. The nurse emerged from this resident room at 1043 hour. At 1046 hour, the RPN left the unlocked medication cart at the top of the hallway near two identified rooms and entered a resident room midway down the hallway. The RPN returned to the cart at 1048hr.

Throughout this time, residents, unregistered staff members and volunteers were observed to be present in the hallway including resident #045.

The DON was interviewed and indicated the expectation was that the medication cart is locked when not in use or when the medication cart is out of sight of the registered staff administering the medications. The DON provided the inspector with policy 3.3, titled "Medication Cart and Cart Maintenance", which indicates the same. [s. 129. (1) (a)]

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 drugs stored in the medication cart are secured and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that there was monitoring and documentation of resident #29's response and the effectiveness of an identified drug being taken over a five day period.

During the RQI it was identified that resident #029 had a change in condition related to being treated for a medical condtion on an identified date.

On the identified date, resident #029 was transferred to the hospital due to experiencing mutiple medical symptoms. Resident #029's returned from the hospital with an identified medical diagnosis. On the identified date the Physician ordered resident #029 to receive a medication for five days to treat the medical condition.

Review of resident #029's progress notes identified two dates and times that an assessment was completed by the nurse related to resident #029's medical condition currently being treated with the identified medication.

During an interview, the Assistant Director of Nursing (ADON) indicated the monitoring of resident #029's health status and the effectiveness of the identified medication should have been documented in resident #029's health record.

Therefore, there was no evidence that there was monitoring and documentation of resident #38's response and the effectiveness of the identified drug being taken on nine shifts from over a five day period. [s. 134. (a)]

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 monitoring and documentation of resident #29's response and the effectiveness of the identified drug being taken or any other drug, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. Related to complaint log #004780-15:

The licensee has failed to comply with LTCHA, 2007, s. 44 (7) whereby an application for admission to the home was declined based on reasons that are not allowable.

On an identified date, #054's application for admission was declined. A discussion was held with the Administrator who indicated the DON at the time of this application had indicated the staff lacked the nursing expertise to provide the required care.

LTCHA, 2007, s. 44 (7) indicates a licensee shall approve an applicant's admission to the home unless,
-the home lacks the physical facilities necessary to meet the applicant's care requirements,
-the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements or
-circumstances exist which are provided for in the regulations as being a ground for with holding.

The current DON reviewed the application and indicated the home should have approved the application as the staff would have been able to address the care needs of the applicant. The applicant is now placed in another LTC home. [s. 44. (7)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure all foods are served using methods to preserve appearance and food quality.

On an identified date at lunch time, residents #047 and #048 were observed being assisted by PSW #108. Resident #047 was given a regular diet which consisted of peas, meat and mashed potatoes with gravy. Resident #048 was provided with a pureed diet consisting of pureed peas, pureed meat, mashed potatoes and gravy.

PSW #108 was observed stirring all food items on resident #047 and #048's plate such that all of the food items were thoroughly mixed together prior to feeding either resident. There was no indication this was a preference or a part of the plan of care for either resident. Several other residents were observed being fed by staff, but did not mix the foods together prior to feeding.

On another identified date, a second dining observation was completed. PSW #116 assisted residents #047 and #048 with their meals and did not stir the foods items together.

Dietitian #115 was interviewed and stated there would be no instances whereby the mixing of a resident's food items would be considered acceptable. [s. 72. (3) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

On an identified date, this inspector made dining observations on an identified unit during the lunch service. At 1201hr, PSW #108 was observed placing a plate of food on the counter directly behind resident #046. At 1206hr, a second PSW was observed to take the plate from the counter and began feeding resident #046 at that time. The food was not reheated.

Residents #047 and #048 were seated at an adjacent dining room table and were given their meals at 1207hr by PSW #108. This PSW provided immediate assistance to both residents, however at 1212hr, PSW #108 was observed to leave the table during the entrée and did not return to further assist either resident until 1217 hr. The food was not reheated.

The care plans of residents #046, #047 and #048 were reviewed. Resident #047 and #048's care plans indicated the residents required total assistance with feeding. Resident #046's care plan indicated the resident occasionally required total feeding and staff indicated the resident had been requiring total feeding at that time. [s. 73. (2) (b)]

Issued on this 21st day of January, 2016

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

Original report signed by the inspector.