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 sions de longue durée

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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
Apr 12, 2016	2016_280541_0010	001041-16	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

AMBER MOASE (541)

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): April 4, 2015

Complaint logs #001041-16 and #002318-16 regarding resident care and services were inspected.

During the course of the inspection, the inspector(s) spoke with the Assistance Director of Nursing, a Registered Practical Nurse, Personal Support Workers and Residents. In addition inspector observed a lunch meal, reviewed resident health care records and reviewed the home's staffing plan.

The following Inspection Protocols were used during this inspection:
Food Quality
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 ensure that plan of care based on an assessment of the resident and the resident's needs and preferences.

Re: Log #002318-16
On April 4, 2016 Inspector #541 spoke to residents regarding the care they receive in the home. One of the residents, resident #001 was asked if he/she requires assistance to get up in the mornings. Resident #001 stated he/she does need help and staff come to get the resident up around a specified time. Resident #001 further stated that staff used to get him/her up one hour earlier but now it is at a later specified time. When asked why the time was changed resident #001 was not sure but asked if the inspector could have the time changed back to the earlier time.

Resident #001's current plan of care was reviewed. The following was indicated:
- Wishes care as soon as awake; will become angry if not done right away. Will go to different staff and complain; and ask repetitively why care is not being done right away

Interventions for this focus were indicated as follows:
• When resident awakens, wishes to be done immediately as resident does not like to wait. Due to high demands, nights not able to provide care at a specified time since it can take a specified length of time. Reassure and voice when care will be done (by day staff).

Inspector #541 interviewed PSW #101 and #102 both of whom confirm that resident #001 prefers to have care provided early and is an "early-riser". PSW #101 informed inspector that a few residents are provided care by the night shift prior to their end of shift at 0700 hours. PSW #101 further indicated there is a list of residents who wish to have their care done earlier and those are the residents on the list. When asked why resident #001 was not on this list, PSW #101 was unsure.

ADON #100 was interviewed regarding how residents are added to the list of care to be provided early in the morning. ADON #100 stated that the following factors are taken into account when adding resident's to the "early-riser" care list:
- who is an early riser and becomes a fall risk
- Resident request
- Level of care required by the resident and level of care able to be provided by night shift staff.

ADON #100 was asked why resident #001 is not provided with care early in the morning. ADON #100 indicated that resident #001 used to be provided with care early in the morning but was removed from the list because the resident seemed to attach to the PSW and the PSW stated she was scared of the resident. Inspector #541 asked if the home tried assigning another PSW to resident #001's early morning care and ADON #100 indicated that they had not.

ADON #100 further stated she will review resident #001's request to have care provided by the night shift staff. [s. 6. (2)]

2. The licensee has failed to ensure that care set out in the plan of care provided to the resident as specified in the plan.

Re: Logs #001041-16 and #002318-16
Concerns were brought forward to the inspector that resident's treatments are not always provided as indicated. Inspector #541 reviewed the Treatment Administration Records (TAR) of four residents.

PSW #104 indicated to Inspector #541 during an interview that PSWs do apply treatment creams but this is at the direction of the RPN. PSW #104 further stated that the RPN documents that the treatment is given. RPN #103 indicated to Inspector that if a resident refuses a treatment or medication, this is coded in the TAR as "refused." RPN #103 confirmed that if the space is left blank, the treatment was not done.

ADON #100 further confirmed that if the TAR was left blank, one can assume the treatment was not provided.

Resident #001's TAR include specified treatments twice daily, another specified treatment to be applied in the morning and off in the evening. A review of resident #001's TAR for a specified month indicates the following:
- Specified treatment not provided twice daily as directed on 6 specified dates in the month.
- Second specified treatment not completed as ordered 5 times in the month.

Resident # 002's TAR includes a specified treatment four times daily. A review of resident #002's TAR for two specified months indicates the treatment was not provided on the following dates:
- Twice on 6 specified dates and once on 1 specified date.

- Treatment not provided at all on one specified date and not provided three times on another specified date.

A family member of resident #002 indicated to the inspector that sometimes resident #002 has difficulty as a result of the treatment not being provided.

Resident #004's TAR includes a specified treatment twice per day. A review of resident #003's TAR for 2 specified months indicates the treatment was not provided once on 4 specified dates.

Resident #001, #002 and #004's treatments were not provided as specified in their plans of care. [s. 6. (7)]

WN #2: 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 licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Re: Log #002318-16
Resident #001's TAR indicates resident is to have a specified medication applied twice daily. A review of resident #001's TAR for a specified month indicates that the medication was not provided twice daily in accordance with directions of the prescriber on 5 dates.

Resident #002 is prescribed a specified medication treatment 4 times daily.

A review of resident #002's Medication Administration Record (MAR) indicates the specified medicated treatment was provided 2 times and not 4 times daily as per directions on a specified date.

Resident #004's TAR indicates resident is to have a medicated treatment applied in the evening. A review of the TAR for a specified month indicates the treatment was not applied on 4 dates.

Resident #005's TAR includes a specified medicated treatment twice daily. A review of resident #005's TAR for a specified month indicates the treatment was not provided once on 4 specified dates.

RPN #103 was interviewed by Inspector #541 and confirmed if the MAR or TAR is left blank for a specific administration time, the medication or treatment was not provided. ADON #100 further confirmed that if the MAR or TAR was left blank, one can assume the medication was not given. [s. 131. (2)]

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Issued on this 12th day of April, 2016

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

Original report signed by the inspector.