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**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 10, 2016 | 2016_236622_0015 | 002871-16 | 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

HEATH HEFFERNAN (622)

### 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): May 31, 2016, June 1-3, 6-9, 2016**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Assistant Director of Nursing, Registered Nurses, Registered Practical Nurses, Personal Support Workers and Residents.**
**In addition the Inspector observed staff to resident interactions, reviewed resident health care records investigation documents and reviewed relevant policies.**

**The following Inspection Protocols were used during this inspection:**
**Dignity, Choice and Privacy**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**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. 2007, c. 8, s. 24 (1), 195 (2).**
**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. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident or neglect of a resident by staff that resulted in risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

Verbal Abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self worth, that is made by anyone other than a resident.

Inspector #622 reviewed critical incident which indicated; resident #001 complained to the Director of Nursing (DON) #100 that on a specified date and time, Registered Nurse (RN) #101 was rude to him/her when he/she asked for a specific medication and made him/her wait for an unacceptable amount of time.
Resident #001 reported he/she requested a specific medication at a specified time. RN #101 told him/her, they would have to wait until everyone else was done getting their medications and they would need to check the order. Resident #001 asked RN #101 if the order had been checked when they were administering medication to another resident, RN #101 replied no, he/she would have to wait.
Approximately 30 minutes later, resident #001 asked RN #101 if he/she could have the medication. RN #101 questioned why he/she needed the medication. Resident #001

gave a reply and RN #101 gave what resident #001 felt was a rude response.

On June 01, 2016, inspector #622 interviewed resident #001 who revealed on a specified date, RN #101 made him/her feel belittled and embarrassed.

On June 01, 2016, inspector #622 interviewed the DON #100 who indicated; the outcome of the investigation was; RN #101 had been unprofessional, had not acted appropriately. RN #101 had acknowledged he/she responded inappropriately to resident #001. RN #101 was educated regarding the expectation to maintain professionalism and is being monitored by the DON.
During the interview, the DON #100 further indicated; the homes expectation is to immediately report incidents of abuse and or neglect to the Ministry of Health and Long Term Care (MOHLTC) and if the incident occurred after hours, the RN in charge would call the MOHLTC after hours pager.
The DON #100 confirmed the incident of alleged staff to resident abuse was not called to the MOHLTC after hours pager nor was a critical incident immediately submitted.

The critical incident was submitted one day following the incident by the nursing home to the Ministry of Health and Long Term Care on a specified date and time.

The finding of non-compliance under s.24.(1)is included in a previous compliance order dated for August 31, 2016; inspection #2016_280541_0009 performed April 12, 2016 by inspector #541. [s. 24. (1)]

---

**Issued on this 10th day of June, 2016**

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

**Original report signed by the inspector.**