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 soins 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
Jun 10, 2016	2016_347197_0013	008536-16	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

JESSICA PATTISON (197)

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 2, 3, 6-8, 2016

Five critical incidents were inspected as part of this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, an Assistant Director of Nursing, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

The inspector also reviewed resident health care records, internal investigation files, the home's prevention of abuse/neglect policy and observed resident care.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 following finding is related to log 016526-16:

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

Resident #004's care plan indicates that the resident requires total feeding assistance and does not actively participate in the feeding process.

Resident #004 reported that on a specified date, PSW #104 did not provide the feeding assistance that was needed with their snack.

PSW #104 indicated during the investigation process that the resident was given a snack but that they did not remain with the resident to assist with feeding.

Therefore, PSW #104 did not provide the required feeding assistance as per the resident's plan of care. [s. 6. (7)]

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 care set out in residents' plans of care related to feeding assistance is provided as specified in the plan, 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 :

The licensee has failed to comply with LTCHA 2007, s. 20 (1) in that staff members did not follow the home's written policy that promotes zero tolerance of abuse and neglect of residents.

The home's abuse policy/procedure F-20 "Zero Tolerance of Abuse and Neglect Program", last revised May 1, 2015, states the following on page 3 of 16:

"IV. Overview of Investigation & Reporting of Abuse and Neglect

a) Investigation and Reporting (including notification to SDM)

3) All staff must immediately report every alleged, suspected or witnessed incidents of:
a) Abuse of a resident by anyone, and
b) Neglect of a resident by the licensee, a staff member (or affiliate) of the Home.

1. The home submitted a Critical Incident Report alleging that two residents had been abused by staff member #102. Both instances were witnessed by the same staff member, PSW #101. PSW #101 witnessed the first incident of abuse towards resident #002 on a specified date . This PSW stated that what was observed was concerning, but did not report it to anyone. PSW #101 then witnessed the second incident of abuse three days after the first, towards resident #003, by the same staff member.

Management was not notified of either abuse until the morning after the second occurrence. Therefore, neither incident of alleged abuse was reported immediately as per the home's policy. [s. 20. (1)]

2. The home submitted another Critical Incident Report alleging staff to resident abuse. Resident #004 had reported to PSW #103 that PSW #104 had been abusive and neglected to provide care. The investigation file indicated and the DON confirmed in an interview on June 7, 2016, that PSW #103 did not report the incident to management until three days after the alleged abuse occurred.

PSW #103 did not report the allegation of abuse/neglect immediately, as per the home's policy.

Compliance Order #001 was issued on April 12, 2016 by Inspector #541 with a compliance date of August 31, 2016. Failure to comply with the home's prevention of abuse and neglect policy was included as grounds for this Compliance Order. A follow-

up inspection will take place after the compliance date to ensure the home is following their prevention of abuse and neglect policy. [s. 20. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg. 79/10, s. 97(2) in that a resident's SDM was not notified of the results of an abuse investigation immediately upon completion.

The home submitted a Critical Incident Report indicating that a staff member was alleged to have physically abused two residents, #002 and #003.

The home's investigation file was reviewed and there was no indication that the substitute decision-makers (SDM's) of the two residents were notified of the results of the investigation upon completion.

During an interview with the Director of Nursing on June 7, 2016, she indicated that she did speak to the SDM of resident #003 in person upon completion of the investigation but stated she did not speak to the SDM of resident #002.

During an interview with ADON #100 on June 7, 2016, she indicated that she did not notify the SDM of resident #002 of the outcome of the abuse investigation immediately upon completion. The ADON further stated that she did not think any staff member from the home had made contact with this SDM to let them know the outcome of the abuse investigation. [s. 97. (2)]

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.