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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## 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 |
|---|---|---|---|
| Oct 31, 2016 | 2016_505103_0044 | 013485-16 | 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

DARLENE MURPHY (103), CATHI KERR (641), WENDY BROWN (602)

### 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): October 24-27, 2016.**

**The following intakes were included in this inspection: Logs #028666-16 (resident fall), #029127-16 (alleged resident to resident abuse), #029860-16 (resident fall), #030232-16 (resident fall), and #030296-16 (alleged resident to resident abuse).**

**During the course of the inspection, the inspector(s) spoke with residents, the Resident and Family Council representatives, Personal Support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Physiotherapist, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.**

**During the course of the inspection, the inspectors conducted a full walking tour of the home, reviewed resident health care records and home policies related to fall prevention and restraints, observed resident care, medication administration, medication storage and infection control practices.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**

**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<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. 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 relates to Log #029860-16:

The licensee has failed to ensure that the care set out in resident #027's plan of care was provided as specified in the plan.

Resident #027's health care record was reviewed and indicated the resident was high risk for falls. On an identified date, resident #027 sustained a fall from the wheelchair. RPN #105 was interviewed and indicated the PSW staff found the resident on the floor. The RPN indicated the resident was assessed for injuries and sent to hospital for further assessment and treatment.

RPN #105 stated she had noted the resident's chair alarm did not sound prior to this fall. The RPN indicated the alarm was initially believed to have been turned off at the time of the fall, but was later found to be non functioning. The RPN indicated the PSW staff are responsible for checking all fall prevention interventions to ensure they are in good working order throughout their shift.

Resident #027's care plan, in place at the time of the fall, was reviewed and indicated the following:
-resident has a velcro lap belt with a personal alarm in place when in the wheelchair for safety.

The DOC was interviewed and indicated staff are responsible for ensuring fall prevention interventions are in good working order at all times. [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 the fall prevention interventions for resident #027 are in place as outlined in the plan of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

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

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure all doors leading to non-residential areas were kept closed and locked when not supervised by a staff member.

On October 24, 2016, Inspector #641 noted during the initial tour of the home that the door to the electrical closet located on Oak Villa was not closed and locked. The handle was observed to be locked, but the door had not been fully closed and was therefore able to be opened by the inspector. While touring the Maple Villa, the same inspector found a resident care supply cupboard was not closed and locked. Once again, the handle was observed to be locked, but the door had not been fully closed and was able to be opened by the inspector.

Upon the discovery of the two unlocked doors, staff were notified and confirmed the doors were to be closed and locked when not supervised by staff. Staff secured both doors when notified by the inspector. Subsequent checks of these two doors were completed throughout the inspection period and the doors were found to be locked with each check. [s. 9. (1) 2.]

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**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 an area or a medication cart, that was secure and locked.

On October 26, 2016 at 1400, inspector #641 observed two medicated creams in resident #009's shared bathroom. Both had prescription labels with resident #009's name on it and a hand written message with instructions related to the application was observed sitting with the medicated creams. On Oct 24, 2016, inspector #103 observed two medicated creams with prescription labels for resident #029 in the shared bathroom.

Inspector #641 interviewed RPN #105 and she stated that the PSW's do apply medicated creams. She indicated the medicated creams are put in the resident's bathroom at the start of the shift so that they are available for the PSWs to apply them and are picked up later in the shift.

Inspector #641 interviewed the Director of Care on October 26, 2016. She stated that the PSW's do apply prescribed creams to the resident at the direction of the registered staff. She stated that the expectation of the home was that the PSW would get the cream from the registered staff at the time it needed to be applied, and return it to the registered staff when they were finished with it.

The licensee failed to ensure that all medications were secure and locked at all times. [s. 129. (1) (a)]

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**Issued on this 31st day of October, 2016**

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

**Original report signed by the inspector.**