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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2017	2017_520622_0036	021983-17	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

HEATH HEFFERNAN (622)

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): October 05, 10, 11, 12, 13, 2017

Log #021983-17 related to a complaint related to medication administration and an identified resident's adverse event while eating.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), the Physician, the Registered Dietitian (RD), Registered Practical Nurses (RPN), a Personal Support Worker (PSW), the Substitute Decision Maker (SDM) and the resident.

Also during the course of the inspection the inspector reviewed resident health records and the nursing homes applicable complaint investigation notes, policies related to nutrition and hydration and choking.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The following non-compliance is related to Log #021983-17

The licensee has failed to ensure that resident #001 was reassessed when the resident's care changed as a result of an adverse event while eating.

A complaint submitted to the Ministry of Health and Long Term Care indicated on a specified date, resident #001 who was capable of making his/her own decisions requested a specified food item during the meal service. Resident #001 alleged he/she experienced a reaction to the specified food item which caused him/her to have an adverse event. Resident #001 asked for help from PSW #107 and requested PSW #107 inform the nurse about the alleged reaction and adverse event. Registered Practical Nurse (RPN) #100 did not visit resident #001 until approximately three hours later and no one assessed resident #001 after he/she had an adverse event.

A review of the homes investigation statement from PSW #107 indicated on a specified date, resident #001 rang his/her call bell at a specified time. When PSW #107 answered the call bell, resident #001 was noted to be anxious and stated he/she was having an alleged reaction to the specified food item. Resident #001 further indicated to PSW #107 that he/she was having an adverse event. PSW #107 noted resident #001 appeared fine and suggested to the resident that the specified food item may have been too chunky. PSW #107 indicated she informed RPN #100 of the conversation she had with resident #001 regarding his/her adverse event. PSW #107 also informed RPN #100 that he/she had not observed resident #001 showing symptoms of the adverse event while she was with the resident for 10 to 15 minutes. Furthermore PSW #107 believed resident #001 had an adverse event but this appeared to be resolved before her arrival.

During an interview with inspector #622 on an identified date in October 2017, RPN #100 indicated if a resident was noted to have an adverse event, the expectation would be the registered staff would assess the resident immediately. RPN #100 indicated she had not assessed resident #001 when she had been informed by PSW #107 that resident #001 had complained of an adverse event on the specified food item. RPN #100 indicated she trusted PSW #107 who indicated resident #001 was not in distress.

During an interview with inspector #622 on an identified date in October 2017, the DON indicated she would have expected RPN #100 to have assessed resident #001 at the time she had been informed of the adverse event by PSW #107.

Therefore the licensee failed to ensure that resident #001 was reassessed when the resident's care changed as a result of an adverse event while eating. [s. 6. (10) (b)]

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 residents are assessed when the resident's care has changed as a result of an adverse event while eating., to be implemented voluntarily.

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 has failed to ensure that a specified medication was administered to resident #001 in accordance with the directions for use specified by the prescriber.

On a specified date, resident #001's SDM indicated to the inspector that resident #001 was not receiving a specified medication, had requested it and was told by the RPN that resident #001 had discontinued it. The SDM indicated resident #001 had not discontinued the medication. The SDM also indicated on a specified date, nursing home staff had notified him/her that resident #001's specified medication had been stopped on a specified date seven days earlier due to an accidental discontinuation of the medication.

On a specified date, resident #001 indicated to the inspector that the nurses stopped bringing his/her specified medication. Resident #001 indicated he/she asked RPN #100

why he/she had not been receiving the medication and was informed it had been discontinued by resident #001. Resident #001 indicated he/she had not discontinued the specified medication and furthermore had been informed by an RN on a later date that the specified medication had been accidentally discontinued.

A review of the progress notes dated a specified date by RPN #100 indicated she had placed a note on the physician rounds for physician #103 to review. The note indicated resident #001 had asked why he/she was no longer receiving his/her specified medication as he/she had not given consent for it to be discontinued.

A review of the Physician rounds note dated a specified date indicated physician #103 had noted the medication error related to resident #001's specified medication. Physician #103 indicated that resident #001 had routine twice daily dosing and when needed (prn) dosing of the specified medication and only the prn dosing of the specified medication was to be stopped. The twice daily routine order for the specified medication was to be left in place however the order was stopped and resident #001 was no longer receiving the medication in error.

A review of the Medication incident report indicated there had been a processing error and resident #001 missed multiple doses of the specified medication over the seven day period.

A review of the home's internal complaint reporting form indicated a medication error had been made, the routine twice daily dose of the specified medication had been discontinued rather than the intended PRN dose. RPN #100 admitted to rushing and not transcribing the order properly and the second RPN performing the second check on the order transcription did not notice the error.

A review of the Electronic Medication Administration Record (eMar) for September and October 2017, indicated resident #001's routine twice daily specified medication had been stopped on a specified date in place of the PRN dose. Resident #001 had not received his/her routine twice daily dose of specified medication for a seven day period.

During an interview with inspector #622 on an identified date in October 2017, RPN #100 indicated that she had made an error when transcribing the order, she discontinued the routine twice daily dose of the specified medication in the place of the PRN order.

During an interview with inspector #622 on an identified date in October 2017, the DON

indicated a medication incident occurred, the routine dose of the specified medication was discontinued in error and as a result resident #001 did not receive the specified medication as ordered.

Therefore the licensee failed to ensure that resident #001 received his/her routine dosage of a specified medication as ordered by the prescriber. [s. 131. (2)]

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 residents are administered medications in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 27th day of October, 2017

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

Original report signed by the inspector.