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
Dec 13, 2017	2017_520622_0043	026078-17	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): November 22, 23, 2017

Log #026078-17 related to the unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), the Physician, Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

Also during the course of the inspection the inspector reviewed health records, the homes policies titled; "Falls Prevention and Management Program" # H-10 and "Head Injury" # H-100, and the homes related incident file.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The Licensee has failed to ensure that the Licensee's Falls Prevention and Management Program including the Head Injury policy and procedure # H-100 which has been instituted or otherwise put in place has been complied with.

O. Reg. 79/10, s. 48 (1) states; every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10, s. 49 (1) states; the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The Licensee's Head Injury policy and procedure # H-100 dated revised September 15, 2017, indicates that the procedure for a head injury is as follows;
Complete an electronic Head Injury Routine Assessment including; blood pressure, pulse, respirations, pupils and level of consciousness every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every hour for four hours. Record on a head injury routine form and nurses notes.

A review of Critical Incident System (CIS) report dated a specified date indicated resident #001 had fallen on a specified date. Resident #001 denied pain however appeared tired, was placed on head injury routine and the vital signs remained stable. A specified injury developed over the night shift. Resident #001 was assessed by the physician the day after the fall and changes were made to the resident's medication. Resident #001's condition continued to decline and he/she passed away six days post fall.

Resident #002 of a specified age fell on a specified date and sustained a head injury.

Resident #003 of a specified age had an un-witnessed fall on a specified date and sustained a head injury.

A review of the electronic health record titled; Head Injury Routine (24 hour) assessment dated a specified date for resident #001 indicated the documentation showed that the

head injury routine was completed for every 15 minutes for the first hour post fall, then for every 30 minutes for one hour, hourly documentation was done for two hours. There was no indication that the resident was assessed the last two hours of the required head injury routine assessment. Furthermore there was no other documentation found in resident #001's health records related to the required missing head injury routine assessments.

A review of the electronic health record titled; Head Injury Routine (24 hour) assessment dated a specified date for resident #002, indicated the documentation shows that the head injury routine assessments were completed every 15 minutes for the first hour post fall and hourly for three hours. There was no indication that the resident was assessed every half hour for the second hour post fall and the last hour of the required head injury routine assessment. Furthermore there was no other documentation found in resident #002's health records related to the required missing head injury routine assessments.

A review of the electronic health record titled; Head Injury Routine (24 hour) assessment dated a specified date for resident #003, indicated the documentation shows that the head injury routine assessments were completed hourly for four hours. There was no indication that the resident was assessed every 15 minutes for the first hour post fall and every thirty minutes for the second hour of the required head injury routine assessment. Furthermore there was no other documentation found in resident #003's health records related to the required missing head injury routine assessments.

During an interview with inspector #622 on November 23, 2017, RPN #103 reviewed the licensee’s head injury policy #H-100 and indicated the resident would be assessed every fifteen minutes for the first hour, then every thirty minutes for the second hour and every hour for the next four hours. RPN #103 further indicated if the head injury assessments for the third and fourth hours were not documented in the electronic chart for resident #001 it would be assumed they were not completed. It is the homes expectation that the policy be followed so the head injury assessments should have been done.

During an interview with inspector #622 on November 23, 2017, the home's Director of Nursing #101 indicated that residents #001, #002, #003’s head injury routines should have been completed according to the licensee’s procedure.

Therefore the Licensee failed to ensure that the Licensee's Falls Prevention and Management Program including the Head Injury policy and procedure # H-100 which was instituted and put in place had been complied with for residents #001, #002, #003. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 13th day of December, 2017

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

Original report signed by the inspector.