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

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 # / No de registre	Type of Inspection / Genre d'inspection
Mar 7, 2018	2018_589641_0010	003651-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the County of Hastings
235 Pinnacle Street P.O.Bag 4400 BELLEVILLE ON K8N 3A9

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

CATHI KERR (641), JESSICA PATTISON (197), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): February 20, 21, 22, 23, 26, 27, 28, 2018

The following logs were inspected during this inspection: Log #023918-17, #025432 -17 and #026388-17 related to alleged resident to resident abuse; #024267-17, #024404-17, #026577-17, #027419-17, #001699-18 related to falls with injury; #024782-17 related to an unexpected death and #025337-17 related to a possible medication incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Assistant Directors of Nursing (ADON), the RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist, Activation Coordinator, Activation Aides, Family Council President, Resident Council President, residents and residents' family members.

During the course of the inspection, the Inspectors conducted a tour of the home, observed medication administration and written processes for handling of medication incidents and adverse drug reactions, reviewed resident care and services, staff to resident and resident to resident interactions, resident health care records, infection control practices, resident and family council minutes, the home's staffing schedules for the nursing department, and policies and procedures related to Falls prevention, Skin and Wound, Infection Control and Medication Administration.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **3 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 :

1. The licensee has failed to ensure that any policy instituted or otherwise put in place is implemented in accordance with all applicable requirements under the Act, and complied with.

O. Reg. 79/10, s.30(2) indicates that the licensee ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee's Skin and Wound Care Policy D-5, last revised September 15, 2017 indicated on page 4 under Residents with Pressure Injuries, "Weekly, RNs/RPNs will complete a Wound Assessment Tool with dressing change, evaluating the progress using the Bates Jensen tool".

A review of the Resident Assessment Instrument (RAI) for a specified date, indicated that resident #032 had two wounds.

Inspector #641 reviewed resident #032's health care record related to skin and wound care for a specified 12 week period. There was documentation of wound one in the progress notes under the heading skin tear note on three specified dates; and under the heading ulcer/wound note on eight specified dates. The Wound Assessment Team had completed assessments of wound one on five specified dates. During the same 12 week period of time, there was only one Wound Assessment Tool completed documenting an assessment of the resident's wound one. There were no documented assessments of resident #032's wound one for two specified weeks.

There was documentation of resident #032's wound two in the progress notes under the heading skin tear note on two specified dates; and under the heading ulcer/wound note on three specified dates. The Wound Assessment Team had completed assessments of the wound two on three specified dates. During the same period of time, there were no Wound Assessment tools completed documenting an assessment of the resident's wound two. There were no documented assessments of resident #032's wound two for five specified weeks.

A review of the Resident Assessment Instrument (RAI) for a specified date indicated that resident #011 had a wound. The RAI assessment for the next quarter indicated the wound had deteriorated.

Inspector #641 reviewed resident #011's health care record related to skin and wound care for a specified 12 week period. There was documentation of the wound in the progress notes under the heading skin tear note on one specified date; and under the heading ulcer/wound note on two specified dates. The Wound Assessment Team had completed assessments of the wound on five specified dates. During the same 12 week period of time, there were only two Wound Assessment Tools completed documenting an assessment of the resident's wound. There were no documented assessments of resident #011's wound for six specified weeks.

During an interview with Inspector #641 on February 22, 2018, RPN #100 indicated that a wound assessment tool was to be completed at least once per week on all residents with wounds, as well as completing an ulcer/wound weekly note with each dressing change.

During an interview with Inspector #641 on February 23, 2018, the Assistant Director of Nursing (ADON) #104 indicated that the expectation of the home related to documentation for skin and wound care was that each wound would be assessed by the registered staff on the floor at least once per week and both a Wound Assessment Tool and a progress note would be completed at that time. ADON #104 specified that in addition, the wound team would do an assessment of the resident's wound, ranging from weekly to monthly depending on the severity and stability of the wound.

During an interview with the Inspector on February 27, 2018, the Director of Nursing (DON) indicated that the expectation of the home was that all wounds stage two or greater would have a documented assessment weekly by the registered staff. The Skin and Wound Care Policy D-5, last revised September 15, 2017 was reviewed by the Inspector with the DON, specifically page 4 under Residents with Pressure Injuries, RN/RPNs, which states "Weekly, RNs/RPNs will complete a Wound Assessment Tool with dressing change, evaluating the progress using the Bates Jensen tool". The DON acknowledged that the Wound Assessment Tool should be completed weekly but that it wasn't always documented by the registered staff.

The licensee had failed to ensure that their policy related to skin and wound care, specifically weekly assessments using the Wound Assessment Tool, had been implemented. Log #024782-17 [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the licensee's written medication protocols for a

specified medication were complied with.

O. Reg. 79/10, s.114(1) indicates that the licensee shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

Inspector #531 reviewed the licensee’s medication incidents for a specified three month period. Three medication incident reports were reviewed.

A review of resident #036's physician orders indicated that resident #036 was to be administered a specified medication following a specific protocol.

The licensee's protocol for the administration of this specific medication indicated that the physician was to be contacted via fax for orders related to the administration of this medication, depending on the resident's current lab results.

A review of the medication incident report indicated that on a specified date, RPN # 127 checked and documented resident #036's lab results. RPN #127 did not fax the physician order sheet to the physician and administer the specified medication as it had been ordered previously.

During an interview with Inspector #531, the ADON #124 indicated that RPN #127 checked and documented the lab result for resident #036, however RPN #127 did not fax the physician order sheet to the physician to review for new orders. The ADON indicated RPN #127 continued to administer the specified medication as it had been previously ordered. The ADON indicated that the omission was noted three days later and the physician was notified at that time. There were no untoward effects to resident #036.

The ADON #124 indicated that the licensee policy and protocols for this specific medication were not complied with.

RPN #127 was not available for an interview. [s. 8. (1) (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 that the plan, policy, protocol, procedure, strategy or system related
specifically to the Skin and Wound Care Policy and Medication Protocols for a specified medication, are complied with, to be implemented voluntarily.

WN #2: 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 whereby drugs that are stored in an area or a medication cart were not secured and locked.

On February 22, 2018, the following observations were made: RPN #102 administered medication to resident #20, in the resident’s room, leaving the medication cart outside in the corridor unlocked, and out of the registered staff member's sight.

On the same day, the medication cart was left unlocked and out of the staff member's sight while attending to resident #033 in the resident's room. RPN #102 proceeded to administer medications to resident #015 in the resident’s room, resident #020 was wandering in the vicinity of the medication cart at that time.

On February 22, 2018, at 1200 hours, RPN #102 was observed at the entrance to the dining room. RPN #102 administered medication to resident #033, resident #034 and #035 leaving the medication cart unlocked and out of the sight of the registered staff member. Inspector #531 observed a number of residents and family members in the vicinity of the unlocked medication cart at this time.

During an interview with RPN #102, the RPN acknowledged the medication administration cart was unlocked and out of sight of the RPN. The RPN indicated that the expectation was that the medication cart be locked if out of sight of the registered staff member.

The Medication Administration and Documentation Policy No. 4.6
Procedure states:
2. Keep unlocked cart in view at all times and ensure that the cart is locked if left unattended or out of view.

The DOC was interviewed on February 22, 2018 and indicated that the expectation was that the medication cart is locked if out of sight of the registered staff member. [s. 129. (1) (a)]

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 drugs stored in an area or a medication cart are secured and locked, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 failed to ensure that no drug was administered to resident #037 unless the drug had been prescribed for the resident.

Inspector #531 reviewed the licensee's medication incidents for a specified three month period. Three medication incident reports were reviewed.

Inspector #531 reviewed resident #037's physician orders which indicated that resident #037 had been prescribed three specific medications to be administered at 0800. A review of the incident reported on a specified date, indicated that RPN #112 administered two different medications to resident #037 that were not prescribed for that resident.

On February 28, 2017 during an interview with inspector #531and review of the incident, the ADON #124 indicated that on a specified date, RPN # 112 had administered two medications that were not prescribed for resident #037. The ADON indicated that RPN

#112 immediately notified the physician and monitored the resident's health status hourly for twelve hours. There were no untoward effects to resident #037.

The licensee failed to ensure that no drug was administered to resident #037 unless the drug had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #531 reviewed the licensee's medication incidents for a specified three month period. Three medication incidents were inspected.

Inspector #531 reviewed resident #033 physician orders which indicated that the resident had been prescribed a specific medication each morning and a different medication at 2100 hours.

During an interview with inspector #531 on February 28, 2018, the ADON #124 indicated that on a specified date, RPN #111 administered the medication that had been prescribed for resident #033 for 2100, at 0800 hours and not the specified 0800 medication. The ADON indicated that the RPN recognized the error and notified the physician, the SDM and monitored the resident throughout the shift. The ADON indicated that there were no untoward effects to the resident. RPN #111 was not available for an interview.

The licensee failed to ensure that drugs were administered to resident #033 in accordance with the directions for use specified 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 that no drugs are administered to a resident in the home unless the drugs have been prescribed for the resident and that drugs are administered to the residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 32 where by resident #016 did not receive individualized care with specific grooming tasks on a daily basis.

Resident #016's current plan of care includes specified directions related to grooming.

On February 22, 2018 during an interview with resident #016's Substitute Decision Maker (SDM), the SDM indicated that resident #016 was not being groomed as specifically directed on a daily basis and that the SDM has had to assist resident #016 with this specific grooming task on multiple occasions when the SDM visits with the resident.

On February 26 and 27, 2018 during separate interviews with inspector #531, PSW #114 and #116 both indicated that they were aware that staff needed to set resident # 016 up so that the resident could start the grooming task and then the staff would assist with completing the specified task. They indicated that resident #016 is not always provided assistance with this specified task on a daily. Both PSWs indicated that resident #016 is guaranteed to get assistance with this specified task on bath days which was twice per week. PSW #116 indicated that there is not always time to provide the assistance required. PSW #114 specified that if they weren't able to complete the specified task for resident #016 during their shift, then they would tell the RPN who would mention it during shift change report so that it would be completed on the next shift.

On the same day the Administrator indicated during an interview that the expectation is that if a resident has not been provide individualized care on the day shift the evening staff would complete the care for the resident. [s. 32.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

Upon review of the Residents' Council meeting minutes for a specified meeting, it was noted that section 5.0 titled Resident Satisfaction Survey, stated the following:
No changes were made to the survey in order to compare results with 2016.

During an interview with the Inspector, the Activation Coordinator indicated that the home did not seek the advice of the Residents' Council in 2017, as the Activation Coordinator had received direction from the administration of the home not to make changes to the survey in order to compare to the previous year's results.

An interview with the Administrator of the home on February 28, 2018 confirmed that direction was given to the Activation Coordinator not to change the satisfaction survey for benchmarking purposes.

Therefore, the home did not seek the advice of the Residents' Council in developing and carrying out the 2017 satisfaction survey. [s. 85. (3)]

2. The licensee has failed to ensure that they seek the advice of the Family Council in developing and carrying out the satisfaction survey for 2017.

Inspector #641 reviewed the responses from the Family Council representative, that indicated that the family council had not had an opportunity to make suggestions for changes to the 2017 survey.

During an interview with Inspector #641 on February 28, 2018, Activation Coordinator (AC) #113 indicated that the AC #113 had attended a specified meeting of the Family council and outlined for them the process for the Resident Satisfaction Survey over the next few months. At that time, AC #113 indicated having been directed by the

administration not to seek input from the Family Council as to any suggestions for changes they may like to see in the 2017 satisfaction survey. The AC specified being aware of the legislation requirements that the family council have an opportunity to review the survey prior to it being implemented and make suggestions if they so desired.

Inspector #641 reviewed the minutes of the Family council meeting for a specified date which documented that the Activation Coordinator had described the three month process to the family council and answered some questions related to that process. There was no indication in the minutes that the family council had been given an opportunity to have input into the survey.

The licensee failed to ensure that the Family Council had been consulted in developing and carrying out the satisfaction survey for 2017. [s. 85. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection and control program.

On February 23, 2018, during the noon medication administration, RPN #102 was observed preparing and administering medications to five residents without performing hand hygiene before or after resident and or resident environment contact. During this same observation, RPN #102 was observed touching the medication cart, the electronic eMAR monitor, glucometers and other equipment without hand hygiene performed before or after contact with the residents.

RPN #102 indicated to inspector #531 that hand hygiene was to be performed before and after contact with the resident and or resident environment, which includes before and after medication administration. RPN #102 indicated being aware of the practice but having forgotten to do it.

The Home's "Routine Practices and Additional Precautions policy " IC-120 states:
Policy: Routine Practices reduce the risk of transmission of microorganisms

Procedure- Routine Practices:
Hand Hygiene
Hand hygiene indications for health care providers when providing care are:
• Before and after all resident care such as feeding, dressing, bathing, toileting and administering medication.
• After removing gloves,
• Before and after handling food
• After using the toilet
• After handling items such as equipment and linens
• When hands are visibly soiled

The DON indicated to inspector #531 during an interview that it is an expectation that hand hygiene is to be performed consistently by all staff. The DON further indicated that all staff have had annual education regarding infection control practices and such includes hand hygiene (and the hand hygiene policy # ICP H-4) and the importance of the same. [s. 229. (4)]

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

Issued on this 8th day of March, 2018

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

Original report signed by the inspector.