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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 5, 2013	2013_179103_0013	O-000063-13	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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

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

---

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 27-28, 2013

A total of four critical incidents were reviewed during this inspection with the following log numbers, #O-000063-13, O-000094-13, O-000095-13, and O-000142-13.

During the course of the inspection, the inspector(s) spoke with a Registered Practical Nurse, a Registered Nurse and the Director of Nursing.

During the course of the inspection, the inspector(s) made resident observations and reviewed resident health care records.

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

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

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

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 licensee has failed to comply with LTCHA, 2007 s. 6 (7) whereby the care set out in the resident plan of care was not provided to the resident as specified in the plan.

On an identified date, Resident #2 reported to the Director of Nursing that Personal Support worker (PSW) S#100 had assisted him/her with a tub bath and completed the transfer in and out of the tub without the assistance of a second staff member.

Resident #2's plan of care in effect for bathing stated, two person physical assist in and out of tub. The PSW failed to provide bathing care to resident #2 in accordance with the plan of care.

2. On the same identified date, Resident #6's room mate overheard the resident asking S#100 to take him/her to the washroom. The PSW advised the resident "you are wearing a brief and that's what it's for" and declined to take the resident.

Resident #6's plan of care for toileting indicated, one person constant supervision and physical assistance for safety, remind and take as needed. The PSW failed to toilet the resident in accordance with the plan of care for Resident #6.

In an interview with the Director of Nursing, she advised S#100 received disciplinary action in response to the above incidents. [s. 6. (7)]

Issued on this 5th day of April, 2013

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