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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 29, 2013	2013_179103_0036	O-000419-13	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

DARLENE MURPHY (103)

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): July 22-25, 2013

During the course of the inspection, the inspector(s) spoke with Personal support workers, Registered Practical Nurses, Registered Nurses, Laundry staff, the Assistant Director of Nursing and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health care records, the home's complaint process, medication incident reports and the home's labelling process for clothing.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Continence Care and Bowel Management

Falls Prevention

Infection Prevention and Control

Medication

Personal Support Services

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 6 (1) (c) whereby the written plan of care did not provide clear directions to staff and others who provide direct care to the resident.

A complaint was lodged by Resident #1's family indicating the resident's hair was being washed by staff the day following hairdressing appointments. They expressed concern that the money was being wasted and that the resident did not look nice to attend church.

Resident #1's plan of care in effect at the time of the complaint indicated under "Bathing", ensure hair is washed and nails are manicured on bathing day.

The resident bath sheet indicates the resident is bathed every Wednesday and Saturday. The Saturday bath dates indicate "do not wash hair".

The resident plan of care fails to provide clear directions to staff. [s. 6. (1) (c)]

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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 131 (3) whereby a person other than a physician, dentist, registered nurse or registered practical nurse administered a drug to a resident.

On an identified date, a student practical nurse administered the wrong medication to Resident #1. At the time of the incident, the student nurse was under the supervision of a Registered Practical Nurse. Blood work was ordered to monitor the outcome of the error and there was no negative effect on the resident as a result of the error. [s. 131. (3)]

Issued on this 29th day of July, 2013

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