



**Inspection Report
under the *Long-Term
Care Homes Act, 2007***

**Rapport d'inspection
prévus le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

**Ministère de la Santé et des Soins de
longue durée**

Division de la responsabilisation et de la performance du
système de santé
Direction de l'amélioration de la performance et de la
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
September 29-30, 2010	2010_124_9538_29Sep12290 2	Complaint-O-000703

Licensee/Titulaire

The Corporation of the County of Hastings, 476 Dundas Street West, P.O. Box 458, Belleville, ON K8N 5B2
Fax: 613-771-2409

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 Fax: 613-771-2409

Name of Inspector(s)/Nom de l'inspecteur(s)

Lynda Hamilton (124)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to continence care and hazardous products.

During the course of the inspection, the inspector spoke with: the on-site Manager, Director of Care, Assistant Director of Care, one registered practical nurse, one personal support worker and three residents.

During the course of the inspection, the inspector completed a walking tour of two home areas, reviewed the list of residents purchasing their own continence care products, the home's policy and procedures regarding incontinence products, reviewed the continence care products available in the home for resident use and reviewed the Material Safety Data Sheet for Purell 70 Instant Hand Sanitizer.

The following Inspection Protocol was used during this inspection:
Continence Care and Bowel Management


There are no findings of Non-Compliance as a result of this inspection.



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Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. 
Title: _____ Date: _____	Date of Report: (if different from date(s) of inspection). 