

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: August 2, 2023	
Inspection Number: 2023-1149-0005	
Inspection Type: Follow up	
Licensee: Blackadar Continuing Care Centre Inc.	
Long Term Care Home and City: Blackadar Continuing Care Centre, Dundas	
Lead Inspector Bernadette Susnik (120)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 14, 2023

The following intake(s) were inspected:

- Intake: #00020851 - Follow-up to compliance order (CO) #001, from inspection #2022-1149-0002 regarding s. 22 (3) under O. Reg. 246/22, with a compliance due date of June 30, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #1 from Inspection #2022-1149-0002 related to O. Reg. 246/22, s. 22 (3) inspected by Bernadette Susnik (120).

The following **Inspection Protocols** were used during this inspection:

Safe and Secure Home

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

INSPECTION RESULTS

WRITTEN NOTIFICATION: Emergency Plans

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 268 (14) (a)

The licensee has failed to ensure that staff, volunteers, and students were trained on the emergency plans, before they performed their responsibilities.

Rationale and Summary

Registered staff (registered nurses and registered practical nurses) and personal support workers who were required to work at the home (including those that worked at fixed or per-arranged intervals from an employment agency) were not provided with training on the emergency plans before they performed their responsibilities. The licensee's method of training staff on emergency plans was through a self-directed software program before hire and then once per year. The program was not available to staff from an employment agency. RN #100 was from an employment agency and not familiar with the emergency plans or procedures during a power loss. The RN worked regular shifts at the home since November 2022.

The licensee received a rental generator in June 2023, as a supplement to the existing on-site generator. The process of ensuring that the generator was connected to the home's electrical grid, how long the process takes, who would be involved and what building systems each of the generators serviced would need to be known by maintenance staff and the RN and other alternate leads should they not be available. This information was only provided to four RNs who were not from an employment agency on July 19 and 20, 2023.

Failing to have an adequate emergency response staff training program could potentially result in staff not being able to respond quickly and appropriately during an emergency which may impact the safety and security of residents.

Source: Interview with Administrator, RN#100, RPN #101, record review of loss of essential services training module and staff training attendance records.

[120]