Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
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Original Public Report

Report Issue Date: September 11, 2023	
Inspection Number: 2023-1149-0006	
Inspection Type: Critical Incident	
Licensee: Blackadar Continuing Care Centre Inc.	
Long Term Care Home and City: Blackadar Continuing Care Centre, Dundas	
Lead Inspector Carla Meyer (740860)	**Inspector Digital Signature** Paola C Meyer Digitally signed by Paola C Meyer Date: 2023.09.14 11:51:15 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 16th-17th, and 22nd-23rd, 2023

The following intake(s) were inspected:

- Intake: #00005616 - [CI: 2641-000007-22] related to Prevention of Abuse and Neglect.
- Intake: #00014334 - [CI: 2641-000025-22] related to Prevention of Abuse and Neglect.
- Intake: #00093728 - [CI: 2641-000030-23] related to Prevention of Abuse and Neglect.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee failed to ensure that a resident's Daily Observation Record, also referred to by the home as Dementia Observation System (DOS), an intervention used to monitor their responsive behavior was completed.

Rationale and Summary

The resident's clinical records indicated that they required on-going DOS monitoring as they continued to occasionally exhibit inappropriate behaviors towards other residents and staff. The DOS form was to be completed by staff.

A review of the resident's DOS records for an identified date in April 2022 showed missing entries where the resident exhibited behaviors, as well as during a seven-day observation period post a reported incident of abuse towards another resident. In July 2023, and in identified dates in August 2023, the resident's DOS records showed missing entries for all consecutive days.

The Director of Care (DOC) acknowledged that the DOS form was to be completed to its entirety according to the home's policy and acknowledged the gaps in the resident's DOS forms.

By not completing the resident's DOS documentation, effective monitoring of the resident's behaviors and response to their interventions were impacted which placed other residents at risk.

Sources: Interview with DOC, resident's clinical records, review of the home's Responsive Behavior Program, and Standards related to Health Care Records policy. **[740860]**

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to immediately report an incident of resident to resident alleged abuse to the Director.

Rationale and Summary

In accordance with the Fixing Long-Term Care Act, 2021, s.28 (2), a person who has reasonable grounds to suspect that an abuse of a resident by anyone that resulted in risk of harm to the resident shall be reported immediately to the Director.

On an identified date in April 2022, a resident displayed inappropriate behavior towards another resident. The home did not call the after-hours emergency line to report the incident to the Director. The DOC acknowledged that the Critical Incident (CI) report was submitted one day late, and that the after-hours emergency line should have been called.

Sources: CI: 2641-000007-22, residents clinical records, the home's investigation notes, and interview with the DOC. **[740860]**