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

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Original Public Report

Report Issue Date: November 13, 2024
Inspection Number: 2024-1558-0005
Inspection Type: Complaint Critical Incident
Licensee: The Corporation of the County of Hastings
Long Term Care Home and City: Hastings Manor Home for the Aged, Belleville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 5, 6, 7, 8, 12, 13, 2024

The following intake(s) were inspected:

Intake: #00128242 - Critical Incident #M538-000074-24- Alleged resident to resident physical abuse resulting in injury.
Intake: #00130220 - Critical Incident #M538-000080-24 - Alleged resident to resident sexual abuse.
Intake: #00130335 - Critical Incident #M538-000082-24 - Alleged staff to resident physical abuse.
Intake: #00130688 - A complaint related to alleged resident to resident abuse.
Intake: #00130769 - Critical Incident #M538-000081-24 - Alleged resident to resident physical abuse.

The following Inspection Protocols were used during this inspection:

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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;

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for that resident. Specifically, an intervention to monitor a resident was not included in their written plan of care.

Sources: Resident's written plan of care, interviews with an RPN, BSO Lead and the DON.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

1. The licensee has failed to ensure that a monitoring device for a resident was on as set out in their plan of care.

Sources: Interview with the DON, Interview with the BSO lead, review of resident's plan of care and kardex, and review of a critical incident.

2. The licensee failed to ensure that a resident had continuous 1-1 monitoring as set out in their plan of care.

Sources: Review of resident's health care record, observations, and interviews with PSWs and Administrator.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

1. The licensee has failed to ensure that staff complied with the Abuse and Neglect Program. An RPN did not immediately report the alleged abuse of a resident by a staff member to a member of the leadership team.

Sources: Interview with the DON, review of abuse investigation notes and Zero Tolerance of Abuse and Neglect program provided by the LTCH.

2. The licensee has failed to ensure that staff complied with the Abuse and Neglect Program. An RPN did not immediately report the alleged abuse of a resident by another resident to a member of the leadership team.

Sources: Interview with the DON, review of the Zero Tolerance of Abuse and Neglect program provided by the LTCH and review of a critical incident.