Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2020	2020_520622_0014	003776-20, 003834-20, 007128-20, 011960-20, 013591-20, 013845-20, 015200-20, 015652-20, 016704-20	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Hastings
235 Pinnacle Street P.O.Bag 4400 BELLEVILLE ON K8N 3A9

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

HEATH HEFFERNAN (622), AMBER LAM (541)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 4, 9, 10, 11, 14, 2020

The following intakes were inspected during this Critical Incident System inspection:

log # 011960-20/Critical Incident System report (CIS) #M538-000025-20, log # 015200 -20/CIS # M538-000033-20, log # 003834-20/CIS #M538-000010-20, log # 003776-20/ CIS # M538-000009-20, related to incidents that caused injury to residents for which the residents were taken to the hospital and that resulted in a significant change in the resident's health status.

log # 013591-20/CIS #M538-000029-20, log #007128-20/CIS # M538-000016-20, log# 015652-20/ CIS #M538-000035-20 and log # 013845-20/ CIS # M538-000030-20, related to resident to resident abuse.

log #016704-20/CIS #M538-000037-20 related to the unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Behavioural Support RPN, a Behavioural Support PSW and the residents.

Also during the course of the inspection, the inspectors reviewed the critical incident documentation, the licensee's investigation documents, health records, and made observations of resident to resident interaction and residents care and services.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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 O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure the appropriate police force was notified when resident struck resident and sustained an injury.

Resident #003 was struck and knocked to the floor by resident #002. When resident #003 got up, the resident punched resident #004 causing injury.

The police were not notified of the incident.

During an interview with the Assistant Director of Nursing, they indicated the police should have been called as per the licensee's policy.

Sources: Critical Incident, interview with ADON. [s. 98.]

Issued on this 21st day of September, 2020

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

Original report signed by the inspector.