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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: December 2, 2022

Inspection Number: 2022-1558-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: The Corporation of the County of Hastings

Long Term Care Home and City: Hastings Manor Home for the Aged, Belleville

Lead Inspector	**Inspector Digital Signature**
Ashley Bernard-Demers (740787)	Ashley F Bernard-Demers Digitally signed by Ashley F Bernard-Demers Date: 2022.12.02 14:00:32 -05'00'

Additional Inspector(s)
Kayla Debois (740792)
Cathi Kerr (641)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 9, 10, 14-18, 21, and 22, 2022.

The following intake(s) were inspected:

- Intake: #00001524 - [CI: M538-000037-22] Injury resulting in transfer to hospital
- Intake: #00002191 - [CI: M538-000039-22] Fall of resident
- Intake: #00002319 - [CI: M538-000038-22] Injury resulting in transfer to hospital
- Intake: #00003767 - Concerns regarding potential staff abuse of resident (also refer to intake log # 014314-22)
- Intake: #00003896 - [CI: M538-000034-22] Fall of resident, sustained an injury
- Intake: #00004626 - [CI: M538-000048-22] Physical abuse of resident by co-resident
- Intake: #00005819 - [CI: M538-000042-22] Fall of resident, sustained an injury
- Intake: #00006398 - Concerns regarding nursing and personal support services
- Intake: #00006816 - [CI: M538-000045-22] Transferring resident via ceiling lift when it broke injuring a resident
- Intake: #00011309 – [CI: M538-000051-22] Fall of resident, sustained an injury

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

Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards
Resident Care and Support Services
Prevention of Abuse and Neglect
Falls Prevention and Management
Housekeeping, Laundry and Maintenance Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (2)(b)

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 9.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee shall ensure that point-of-care signage indicates that enhanced IPAC control measures are in place. The licensee has failed to ensure that the identification of isolation precautions in a shared room included clear indication as to which resident was on additional precautions.

Rationale and Summary:

The Inspector observed IPAC precaution signage outside of shared resident rooms. There was no indication as to which resident was on precautions.

In interviews with staff members they indicated it should be written on the signage which resident is on precautions.

Prior to the completion of the inspection, the signage specified which resident was on precautions in all of the rooms. No staff were observed entering the rooms without wearing the appropriate PPE.

Sources: Observations completed by Inspector, interviews with staff members.

[740792]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 10.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the Licensee shall ensure that there is access to hand hygiene agents.

Rationale and Summary:
The Inspector observed that twelve of the hand sanitizers that were in circulation had expired. In an interview with a staff member, they indicated that they were aware some of the hand sanitizers were expired.
The use of expired hand sanitizer increases the risk of transmission of infectious agents.

Sources: Interview with staff member, observations by Inspector.

[740792]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee has failed to ensure that an investigation was initiated immediately when a family member alleged abuse towards a resident.

Rationale and Summary:
The resident's family member spoke to a management team member and alleged that a bruise on the arm was a result of abuse.
The investigation notes indicated that the investigation was not initiated immediately.
During an interview with a management team member, they acknowledged that the investigation into the allegation of abuse was not started immediately.
Not immediately investigating potential resident abuse may result in a negative outcome to the resident.

Sources: Critical incident report, interview with management team member, and investigation notes.

[740792]

WRITTEN NOTIFICATION: Maintenance services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 96 (2) (a)

The licensee failed to ensure that procedures were implemented to ensure that the mechanical lift in a resident's room was kept in good repair and maintained at a level that meets manufacturer specifications.

Rationale and Summary:
A critical incident report was received by the Director from the licensee indicating that during morning care of a resident, the motor of the ceiling lift had fallen off the track landing on the resident's chest, causing pain and injury to the resident.
During interviews with the management team members, they indicated that a piece of the ceiling lift track had been removed by the lift contractor the day prior to the incident. A licensee maintenance staff had been in attendance in the room when the track had been removed by the lift contractor. The lift had not been put out of service and no signage, lock out or tag out had been put on the lift to notify the staff that the lift was not in good repair. It was stated that the lift motor should have been removed from the track at the time of the repair, so that it could not have been used.
The licensee's Lock Out policy indicated that a maintenance team member would assess repairs needed and determine if equipment must be locked out, either electrically or mechanically.

There was moderate risk to the resident related to the mechanical lift not being maintained in good repair.

Sources: Critical incident report; interviews with staff members; Lock Out policy; and the licensee's investigation notes related to the incident.

[641]