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: May 17, 2023	
Inspection Number: 2023-1558-0004	
Inspection Type: 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 Kayla Debois (740792)	**Inspector Digital Signature** Kayla L Debois Digitally signed by Kayla L Debois Date: 2023.05.18 14:35:13 -04'00'
Additional Inspector(s) Anna Earle (740789)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1-5, and 8-11, 2023

The following intake(s) were inspected:

- Intake: #00015083 - [IL-07922-AH/M538-000064-22] Resident to resident alleged physical abuse
- Intake: #00015802 - [CI: M538-000065-22] Medication incident
- Intake: #00021801 - [CI: M538-000016-23] Fall of resident with injury
- Intake: #00084290 - [CI: M538-000018-23] Staff to resident alleged abuse
- Intake: #00085926 - [CI: M538-000021-23] Resident to resident alleged sexual abuse
- Intake: #00085948 - [CI: M538-000022-23] Resident to resident alleged physical abuse

The following intakes were completed in this inspection: Intake #00021230, CI #M538-000014-23; Intake #00013260, CI #M538-000056-22; Intake #00018088, CI #M538-000005-23 were related to falls.

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

Medication Management
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the care set out in the safety intervention flow sheets for a resident was documented.

Rationale and Summary:
During an evening in April 2023, an incident of alleged resident-to-resident sexual abuse involving two residents occurred. According to one of the resident's records, they had a history of sexual behaviours. A review of the safety intervention: every twenty minute checks while awake (personal expressions of sexual nature) flow sheets on the Point of Care (POC) documentation system for that evening in April, from 15:00 to 22:40, indicated that this resident was missing documentation for safety checks during this period.

On a day in May, a staff member stated that the safety checks are to be documented in POC every twenty minutes and acknowledged that the documentation was not completed during that evening in April.

Failing to ensure resident's care is documented can increase the risk of uncertainty whether the checks were completed or not.

Sources:
POC documentation for a resident's safety checks, interview with a staff member.

[740792]

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 has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident, by anyone, that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary:
On a day in April 2023, an incident of alleged resident-to-resident sexual abuse, involving two residents occurred. CIS report #M538-000021-23 was submitted to the Director two days after the incident occurred.

On a day in May, a member of the management team acknowledged that the above incident was not immediately reported to the Director.

A delay in reporting critical incidents immediately to the Director can increase the risk of harm/injury to the resident.

Sources:
Review of CIS report #M538-000021-23, interview with a management team member.

[740792]

WRITTEN NOTIFICATION: Altercations and other interactions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee has failed to ensure that interventions were implemented to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary:
On a night in December 2022, two residents were involved in an altercation which resulted in one of the residents sustaining injuries and being sent to the hospital for assessment. According to the other resident's health records, they had a history of aggressive behaviours prior to this altercation. The plan of care for this resident included having one-on-one supervision in place, as stated in an email from a management team member to registered staff the day before the altercation.

On a day in May, a staff member stated that this resident did not have one-on-one supervision during the night when the altercation occurred due to staffing concerns.

By not ensuring the supervision of the resident, there was actual physical harm to another resident that occurred.

Sources:
Email from a management team member to registered staff, interview with a staff member.

[740792]

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use, specified by the prescriber.

Rationale and Summary:
A resident was prescribed insulin and it was to be held if blood sugar was below 6mmol according to the prescriber. On a day in December, a staff member administered insulin to this resident in the morning when their blood sugar was 5.5mmol. In an interview on a day in May, a management team member acknowledged that the resident should not have been administered insulin due to low blood sugar as per prescriber's orders.

Failure to administer medication in accordance with the directions for use as specified by the prescriber placed the resident at risk for health decline and other adverse effects, including hypoglycemia.

Sources:
CIS report #M538-000065-22, resident's health records, and interview with a management team member.

[740789]