

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: June 26, 2024	
Inspection Number: 2024-1558-0003	
Inspection Type: Critical Incident	
Licensee: The Corporation of the County of Hastings	
Long Term Care Home and City: Hastings Manor Home for the Aged, Belleville	
Lead Inspector Carrie Deline (740788)	Inspector Digital Signature
Additional Inspector(s) Tracey-Anne Chapman (000809) Wendy Brown (602) Cathi Kerr (641)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 14, 17 - 21, 24, 25, 2024

The following intake(s) were inspected:

- Intake: #00112442 - CI# M538-000022-24 - Alleged resident to resident abuse.
- Intake: #00113089 - CI # M538-000025-24 - Alleged staff to resident abuse.
- Intake: #00113181 - CI # M538-000026-24 - Alleged resident to resident abuse.

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- Intake: #00115014 - CI # M538-000030-24 - Resident fall resulting in injuries.
- Intake: #00115415 - CI # M538-000031-24 - Alleged resident to resident abuse
- Intake: #00116121 - CI # M538-000035-24 - Fall of resident resulting in injuries.
- Intake: #00116915 - CI # M538-000040-24 - Alleged resident to resident abuse
- Intake: #00117227 - CI # M538-000041-24 - Fall of resident resulting in injuries.
- Intake: #00117936 - CI # M538-000044-24 - Alleged resident to resident abuse.
- Intake: #00118049 - CI # M538-000045-24 - Alleged resident to resident abuse.
- Intake: #00118539 - CI # M538-000050-24 - Alleged resident to resident abuse.
- Intake: #00118814 - CI # M538-000052-24 - Fall of resident resulting in injuries.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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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 (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.

The licensee has failed to ensure that a clip alarm and bed pad alarm was in place for a resident as set out in their plan of care.

Sources:

Resident plan of care, observations, interview with staff.

[000809]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 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.

The licensee has failed to ensure that staff complied with the Abuse and Neglect

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Program. Staff did not immediately report the alleged abuse towards a resident to an appropriate leadership member.

Sources:

Record review, Zero Tolerance of Abuse and Neglect Program review, Interview with staff
[740788]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that staff participated in the implementation of the IPAC program by not complying with N95 masking expectations when on a unit in COVID outbreak.

Sources:

Observations, Interview with staff.
[740788]