Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 23, 2015	2015_348143_0025	O-002244-15	Resident Quality Inspection

Licensee/Titulaire de permis

BELCREST NURSING HOMES LIMITED
250 Bridge Street West BELLEVILLE ON K8P 5N3

Long-Term Care Home/Foyer de soins de longue durée

Belmont Long Term Care Facility
250 Bridge Street West BELLEVILLE ON K8P 5N3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PAUL MILLER (143), JESSICA PATTISON (197), SAMI JAROUR (570), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 10th to 12th, June 15th to 18th, and June 22nd, 2015.

The following Critical Incident Inspections were completed concurrently with the Resident Quality Inspection:
Log # O-001233-14, O-001622-15, O-001653-15 and O-002193-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Directors of Care, the RAI co-ordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, housekeeping staff, Activation Staff, Restorative Care Staff, Physiotherapy Assistant, the Environmental Service Manager, the Program Director, an Administrative Assistant, the Dietary Manager, the President of the Resident's Council, residents and family members.

Inspectors completed tours of all resident home areas, observed resident care and services, observed residents dining, observed medication administration and medication storage areas and reviewed applicable policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

3 WN(s)
1 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are not neglected by the licensee and staff.

The following finding is related to Critical Incident Inspection Log # O-001622-15

Ontario Regulation 79/10 neglect definition states the following:

5. For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified date the home received a phone call from a manager of an inpatient unit of a specified hospital concerning the condition of Resident #44's dentures. The dentures were discoloured (black) with mould and very difficult to remove from the resident's mouth. The home submitted a Critical Incident Report under mandatory reporting abuse/neglect on a specified date to the Ministry of Health and Long Term Care.

On a specified date Resident #44's Substitute Decision Maker (SDM) was in contact with CIATT (Ministry of Health and Long Term Care) and indicated that the resident was in hospital where her\his dentures were removed and found to have mould. The SDM indicated that the resident needs assistance from staff to care for her\his dentures and was not sure how long the dentures were not cleaned.

Review of RAI-MDS/RAPs related to ADL - Functional Rehabilitation Potential for a specified period of time for Resident # 44 indicated that the resident requires supervision

from staff with her\his personal hygiene tasks but for the most part she\he continues to be independent with most aspects of her\his ADL care/abilities.

Review of the plan of care in effect at time of incident for Resident #44 indicated that goals included: dentures will be properly stored & maintained in good repair, provide appropriate oral hygiene. Interventions included: instruct resident in proper handling /storage of dentures, instruct resident in proper oral hygiene techniques and provide supplies for self oral hygiene.

Review of the home's policy titled Denture Care, Policy # NPS 4-0336 developed March 2008 and in effect at time of incident identifies that dentures are cared for to promote comfort and cleanliness of the mouth in particular oral mucosal membrane and to prevent mouth odour, remove food particles, plaque and micro organisms that accumulate in dentures.

The policy directs staff to:
- For Denture Removal:
b) Slide the denture out of the mouth and place it in the denture cup of water with denture cleanser.
e) Cleanse the gums with soft brush or sponge-tip applicator from the front to back to assess for irritation or sores.
- For Denture Cleansing:
b) Hold firmly under running warm water, brush all areas and rinse.
c) Store in a clean, covered denture cup containing water.

- Reporting and documentation:
Note and record any difficulty with chewing or eating, chips or rough areas on dentures. If causing irritation, label dentures and refer to a dentist for correction.

Review of Point of Care (POC) documentation related to mouth care for Resident #44 by PSW's for a two week period of time indicated that:
- Mouth care was done twice a day by the resident.
- Resident's dentures removed and cleaned daily for a specific 5 day period as well as for a three day period.
- Resident's dentures cleaned and in place daily for a two week period of time.

On June 18th, 2015 the Director of Care (DOC) reviewed with inspector the Point of Care (POC) documentation related to mouth care for Resident #44. The DOC indicated to the

inspector that oral and denture care for this resident was not provided as documented as evidence by the mould on the dentures.

RPN S120 documented on a specified date that Resident #44 refuses to allow staff to do her\his mouth care.

On June 18, 2015 inspector #570 spoke with Resident #44's SDM by phone. The SDM indicated that the first time she\he heard about the dentures issues was from the hospital. The dentures had a grey mould build up when removed at the hospital. The SDM indicated that she\he was not informed by the home about any denture issues or about Resident #44 refusing to remove dentures until it was discovered at the hospital.

Review of plan of care in effect at the time of incident and progress notes for Resident #44 for a one month period prior to hospitalization indicated no documentation that the resident refused oral/mouth care and that no strategies were in place to address refusal of oral/mouth care.

In their efforts to address denture care issues, the licensee has updated the care of dentures policy (Index I.D:RCSM-D-20). The policy identifies:
- Any refusal of care must be reported to the registered staff in order that other approaches/interventions can be explored. Care plan must be updated with any change.
- If at any time, a resident that has been completing self-denture care is identified as being non-compliant, this resident's care plan must be updated with new interventions implemented.
- Note and record any difficulty with chewing or eating, chips or rough areas on dentures and notify registered staff and dietary manager.
- POA/SDM to be notified for any changes/issues with resident's dentures.

The licensee has launched a Quality Improvement Project focused on oral care. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents are free from neglect and that staff receive training with respect to dental care and that monthly audits be completed to ensure that staff are compliant with dental care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #44 received oral care that includes mouth care in the morning and evening, including the cleaning of dentures to maintain the integrity of the oral tissue.

The following finding is related to Critical Incident Inspection Log # O-001622-15

On a specified date the home received a phone call from the manager of a hospital inpatient unit concerning the condition of Resident #44's dentures. The dentures were discoloured (black) with mould and very difficult to remove from the resident's mouth. The home submitted a Critical Incident Report under mandatory reporting abuse/neglect

on a specified date.

On a specified date Resident #44's Substitute Decision Maker (SDM) was in contact with CIATT (Ministry of Health and Long Term Care) and indicated that the resident was sent to the hospital where her\his dentures were removed and found to have mould. The SDM indicated that the resident needs assistance from staff to care for her\his dentures and was not sure how long the dentures had not been cleaned.

On June 18th, 2015 inspector #570 spoke with Resident #44's SDM by phone. The SDM indicated that the first time she\he heard about the dentures issues was from the hospital. The dentures had a grey mould build up when removed at the hospital. The SDM indicated that she\he was not informed by the home about any denture issues or about Resident #44 refusing to remove dentures until it was discovered at the hospital.

A review of the plan of care in effect at time of incident for Resident #44 indicated that goals included: dentures will be properly stored & maintained in good repair, provide appropriate oral hygiene. Interventions included: instruct resident in proper handling /storage of dentures, instruct resident in proper oral hygiene techniques and provide supplies for self oral hygiene.

A review of Point of Care (POC) documentation related to mouth care for Resident #44 by PSW's for a specified two week period indicated that:
- Mouth care was done twice a day by the resident.
- Resident's dentures removed and cleaned daily for a three and five day period.
- Resident's dentures cleaned and in place daily for the two period prior to hospitalization.

On June 18th, 2015 the Director of Care (DOC) reviewed with inspector the Point of Care (POC) documentation related to mouth care for Resident #44. The DOC indicated to the inspector that oral and denture care for this resident was not provided as documented as evidence by the dentures having mould on them.

RPN S120 documented on a specified date that the resident refuses to allow staff to do her\his mouth care.

A review of the plan of care in effect at time of incident and progress notes for Resident #44 for the four weeks prior to hospitalization indicated no documentation that the

resident refused oral/mouth care and that no strategies were in place to address refusal of oral/mouth care. [s. 34. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident.

The following finding is related to Critical Incident Inspection Log # O-001653-15

On June 16th, 2015 the Director of Care (DOC) reviewed the incident of abuse with the inspector. The DOC confirmed that the name of the PSW involved with incident was not included in the Critical Incident Report submitted to the Ministry of Health and Long Term Care. [s. 104. (1) 2.]

Issued on this 23rd day of June, 2015

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

Original report signed by the inspector.