Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Apr 27, 2017	2017_596571_0009	000673-17	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

PATRICIA MATA (571), CHANTAL LAFRENIERE (194), JENNIFER BATTEN (672)

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): April 4, 5, 6, 7,10 and 11, 2017

The following critical incident logs were inspected:
029380-16, 006518-17, and 006617-17, all related to one incident of alleged neglect; 006604-17 related to an incident of alleged neglect; 030988-16 related to alleged resident to resident abuse; 003383-17 and 003836-17 related to falls:

Also, one complaint log was inspected:
003836-17 related to a complaint regarding accommodations services.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Assistant Directors of Care, Registered Nurses, Environmental Manager, Physician, Activity Aides, Personal Support Workers, Housekeepers, Dietary Manager, Registered Dietician, RAI Co-ordinator, Activities Manager, residents and substitute decision makers.

In addition, clinical heath records, administrative records, policies, meeting minutes and postings were reviewed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

6 WN(s)
4 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Ontario Regulation 79/10, s. 114. directs the following:

(1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

(2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

(3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

The licensee's has failed to ensure that their medication policy number 6.02 for Quarterly Physician Medication Review is complied with.

The licensee Medication Policy #6.02 titled “Quarterly Physician Medication Review” directs:

-the reviews should be checked against the MAR/eMAR for accuracy before the physician’s visit; any orders placed after the review was printed must be added to the review; the print date and time are indicated on the left margin of the review to assist with this process; similarly, medications discontinued after the printing of the review should be stricken from the form.
-completed reviews must be checked, dated and signed by a second registered staff member; the original copy is then placed in the physician’s order section of the chart
-open sections of any Physician’s Order Sheets dated before the review should be crossed out; a new Physician’s Order Sheet should be inserted into the chart on top of the review so it is clear that the subsequent orders belong to the new quarter;
-any new medication orders, including orders to change or discontinue pouched medications, must be faxed immediately to the pharmacy
-carbon copies of all completed medication review, including those which were faxed, must be submitted to the pharmacy for required record keeping

A review of licensee's medication incidents from December 6, 2016 to March 21, 2017, indicated the following errors:

For resident #029:
-On December 6, 2016, the Physician changed the time of administration for a specified medication from bedtime to once daily so that it could be administered in the morning.
-On the quarterly medication review printed in November, 2016, the specified medication was still ordered for bedtime
-On December 20, 2016, the Physician discontinued this medication by putting a check mark in the "discontinue" column.
-The resident continued to be administered the specified medication in the morning from December 20, 2016, until a nurse noticed on March 11, 2017 that the quarterly medication review dated December, 2016 indicated the medication was discontinued.
-On March 11, 2017, the Physician was notified of the error via telephone and and gave a telephone order to discontinued the medication
-On March 14, 2017, the Physician reordered the medication

For resident #030:
-On December 6, 2016, the Physician changed the time of administration for a specified medication from bedtime to once daily so it could be administered in the morning.
-The resident continued to be administered the medication in the morning until a nurse noticed on March 11, 2017 that the quarterly medication review printed November, 2016 and signed by the Physician December 20, 2016 indicated the medication was

discontinued.
-On March 11, 2017, the Physician was notified of the error via telephone and gave a telephone order to discontinued the medication.
-On March 14, 2017, the Physician reordered the medication once daily

In an interview with the DOC on April 7, 2017, the DOC indicated that the orders should have been discontinued as the Physician checked the discontinue box. Therefore, the two nurses that checked the quarterly medication review, made a medication error by not discontinuing the medication. However, the DOC explained that the Physician’s intention was not to discontinue the orders and that by checking off the boxes, he was just disagreeing with the “bedtime” directions of the order.

In an interview with Physician #129, he indicated that his intention was not to discontinue either of the specified medications but that the time for administration was wrong as he had written once per day on December 6, 2017 so the residents could receive the medication in the morning. When he was alerted on March 11, 2017 that the specified medication for resident #029 and the specified medication for resident #030 should have been discontinued as per the December 2016 quarterly, he ordered both drugs to be discontinued as he was not in the home and did not have access to the resident’s medical health records. When Physician #129 came to the home on March 14, 2017, he reviewed the medical health records and realized that the medication should not have been discontinued so he reordered both. Physician #129 indicated that the both of the specified medications should never have been discontinued only the time for administration was to change from bedtime to the morning. Neither resident #029 nor resident #030 were harmed by the error.

A review of resident #029 and #030’s medical health records indicated that Physician #129 wrote orders on December 6, 2017 to change the times for resident #029’s specified medication and resident #030’s specified medication from bedtime to once per day. The December quarterly Physician Medication review for both residents had the original orders for these medication indicating to give at bedtime. The changed order was not stricken from the quarterly and the new orders from December 6, 2016 were not added to the quarterly.

Therefore, the licensee failed to ensure that staff follow medication policy number 6. 02. [s. 8. (1) (b)]

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 by ensuring registered nursing staff comply with their medication policy number 6.02 for quarterly Physician medication reviews, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the Licensee's "Abuse Policy" ADM-VI-06 dated December 2015 indicated:

Definition of Neglect: Failure to provide a resident with the treatment, care, service, 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.

Staff to resident abuse;
-Staff, visitors and/or residents, acknowledge that abuse may be happening either by witnessing the incident or by communication of the incident by the person being abuse or by other person(s).
-If there is reasonable grounds to suspect abuse has occurred the Assistant Director of Care (ADOC) or the RN charge Nurse (after business hours) is to be contacted immediately.
-the unit nurse will assess the victim for injury (head to toe assessment) and mental

condition, provide first aid and/or send to hospital if necessary.
-if the assailant is on duty, he/she must be sent home on investigatory leave.
-where the assailant is the unit nurse, the RN charge will take on the role of the unit nurse.

A Critical Incident report was submitted indicating that on a specified date RPN #101 initiated a treatment for resident #021 at 1630 hours. POA of resident # 021 arrived at the home at 1855 hours and found the resident still lying on the bed although the treatment was completed. The POA of resident #021 approached RPN #101 to inform the RPN of the situation, that the resident was still on the bed as the treatment was not discontinued as well as resident #021 not having been provided the dinner meal.

Resident #021 requires total assistance with all ADL's related to a recent change in medical condition.

An interview with RPN #101 was conducted by inspector #194 on April 6, 2017 related to allegations of neglect involving resident #021 on a specified date. RPN #101 indicated to inspector #194 that the POA of resident #021 approached the RPN during the shift and informed the RPN that the resident was still in bed and the treatment had been completed. The POA was also concerned that resident #021 had not received the dinner meal. RPN #101 indicated to inspector #194 during the same interview that the treatment was initiated after providing the 1700 medication for resident #021 at 1645 hours. RPN #101 indicated that he/she forgot to return to resident #021's room to stop the treatment and had assumed the PSW's had discontinued the therapy. RPN #101 indicated that he/she had not noticed that resident #021 did not come to the dining room for supper. RPN #101 indicated that he/she went for a supper break between 1800-1900 hours and upon return to the unit was approached by the POA of resident #021. RPN #101 indicated that he/she went to resident #021's room after being informed by POA of the situation and observed the resident to be in no distress. RPN #101 indicated to inspector that he/she did not complete any vital signs or assess the resident #021 at this time also stating that he/she did not document in PCC. RPN did not assess the resident during the remainder of the shift but indicated to inspector #194 that he/she observed resident #021 at 2100 and did not see any signs of distress when administering the medications. RPN #101 indicated to inspector #194 that he/she was aware that POA of resident #021 was very upset about the incident but did not report any of the allegations to the Charge RN. RPN #101 was unable to provide any reason why he/she did not inform the Charge nurse during the evening shift.

On a specified date and time, RPN #101 was approached by POA of resident #021 to report an allegation of neglect related to care. RPN #101 did not complete an assessment of resident #021 post allegations related to complications, did not report the incident to the Charge RN and did not reassess resident #021 during the remainder of the shift for potential of complications. RPN #101 did not comply with the home's abuse policy when the Charge RN was not informed of allegations of neglect and resident #021 was not assessed (head to toe) post allegations of neglect .

Interview with ADOC #113 was conducted by inspector #194 on April 7, 2017 at 1230 hours related to the allegations of Neglect towards resident #021 on a specified date. ADOC indicated that the POA of resident #021 stated that he/she had concerns about an event that had occurred related to a treatment that had been left on the resident.

Therefore, the licensee failed to ensure that RPN #101 assessed resident #021 and informed the RN in charge after an allegation of neglect was brought to his/her attention. [s. 20. (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 the licensee's policy that promotes zero tolerance of abuse is complied with, specifically, assessment of alleged victims of neglect and reporting of allegation of neglect to the nurse in charge, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring.

On April 4 and 5, 2017, Inspector #672 made the following observations:

On April 4, 2017, in a specified resident room, there was an unlabeled personal care items on the back of the toilet in the shared bathroom. There was also an unlabeled personal care items on the sink counter. On April 5, 2017, Inspector #672 observed that there continued to be an unlabeled personal care items on the back of the toilet and two unlabeled personal care items on the sink counter.

On April 4, 2017, in a specified resident room there was an unlabeled personal care item on the back of the toilet in the shared bathroom.

On April 4, 2017, in a specified resident room there was an unlabeled personal care item on the back of the toilet in the shared bathroom.

On April 4, 2017, in a specified resident room, there was an unlabeled personal care item on the back of the toilet, and several unlabelled personal care items on the sink counter. On April 5, 2017, Inspector #672 noted that there continued to be an unlabeled personal care item on the back of the toilet and all items previously identified unlabeled on the sink counter top remained present. The bathroom is shared with the adjacent room.

On April 5, 2017, in a specified resident room, there was an unlabeled personal care item on the back of the toilet in the shared bathroom.

On April 5, 2017, in a specified resident room, there was an unlabeled personal care item on the back of the toilet and three unlabeled personal care items on the counter top of the shared bathroom.

On April 5, 2017, Inspector #571 made the following observations:

On April 5, 2017, in a specified resident room, there were three unlabeled personal care items on the counter in the bathroom two unlabelled personal care item on the back of the toilet in the shared bathroom.

On April 5, 2017, in a specified resident room, there were two unlabeled personal care items on the back of the toilet in the shared bathroom.

On April 5, 2017, in a specified resident room, there were two unlabelled personal care items stored on the grab bar above the toilet in the shared bathroom.

Inspector #672 interviewed ADOC #113 on April 11, 2017. The ADOC indicated that it is the expectation of the home that all resident personal items are labeled within 48 hours of admission and immediately for any new item. According to ADOC #113 to assist in ensuring that all resident personal items are properly labeled, the licensee will periodically assign a staff member to go throughout the home auditing the resident's personal items to ensure they are labeled and if not, put a label onto them.

The licensee has failed to ensure that every resident has their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1) (a)]

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 by ensuring that every resident has their personal items labelled within 48 hours of admission and when acquiring new items, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is administered to a resident in the home unless the drug has been prescribed.

A review of the licensee's medication incidents indicated that a specified drug was administered to resident #004 from December 14, 2016 until March 11, 2017 despite the medication having been discontinued by the Physician on December 13, 2016.

The DOC indicated in an interview with Inspector #571 on April 7, 2017, that the medication error involving the specified medication was discovered by a nurse when the nurse was reviewing the quarterly medication review in March 2017. The Physician was informed immediately and the medication was discontinued. The DOC indicated that although the quarterly medication review completed by the Physician on December 13, 2016 that indicated the licensee should discontinue the medication and despite being checked by two nurses after the order was written, the error was made. In addition, the quarterly medication review was not faxed to the Pharmacy therefore, the pharmacy did not know about the change. The DOC indicated that there were no ill effects to resident #004.

Therefore, the licensee failed to ensure that a specified medication was not administered to resident #004 after is was discontinued by the Physician. [s. 131. (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 by ensuring that no drug is administered to a resident in the home unless it has been prescribed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On April 6, 2017, Inspector #571 observed that the medication rooms on the four resident home areas in the home were accessed by entering a code into a number pad. Stock medication and individual resident medications are stored in unlocked cupboards and unlocked fridge in the medication rooms. The emergency drug box is stored in a locked cupboard in the medication room on the Montgomery unit and the key for the cupboard is left hanging in the room. The locked medication cart with locked narcotic drawer is also stored in the medication room.

In separate interviews on April 6, 2017 with Inspector #571, RN #106 and the DOC indicated that registered staff, the Director of Care, the Administrator and the Environmental Services Manager know the code to the medication room. In an interview with the Environmental Services Manager (ESM) on April 6, 2017, he indicated that he knows the codes to the medication rooms as he programs the codes and can enter the medication rooms in an emergency. The ESM is not a person who may dispense, prescribe or administer drugs in the home nor is the ESM the Administrator.

Therefore, the licensee failed to ensure that the medication rooms are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Inspector #672 observed that on April 10, 2017, on two separate home areas, the PSWs providing the afternoon nourishments were not completing hand hygiene during the nourishment pass. On the Streamway home area, Inspector #672 observed PSW #116 completing the afternoon nourishment pass, collecting dirty glasses from resident rooms, placing them in the dirty basin, then going back to serving cookies and fluids, without completing hand hygiene. There were no bottles of hand sanitizer noted on the nourishment cart. PSW#116 was also picking up the cookies with bare hands, and placing them on a white napkin, to serve to the resident. When Inspector #672 spoke with PSW #116, he/she informed the Inspector that he/she usually completes hand washing/sanitization prior to beginning the nourishment cart, and then at the end, but not during the nourishment pass. On the same date, while Inspector #672 was present on the Belcrest home area completing a staff interview, two PSWs were observed completing the afternoon nourishment pass, and neither PSW was completing hand washing/sanitization between residents, while removing dirty dishes from resident's rooms and placing them in the dirty bin. PSWs were also noted to be picking the cookies up with their bare hands. Therefore, the licensee has failed to ensure that all staff members participated in the infection control program. [s. 229. (4)]

Issued on this 28th day of April, 2017

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

Original report signed by the inspector.