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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 16, 2018	2018_717531_0021	006822-18, 009305-18, 011059-18, 011176-18, 023166-18, 024686-18, 025733-18, 026421-18, 026546-18, 02673	Critical Incident System

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

SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October, 3, 4, 9, 10, 11, 12, 15, 16, 17, 18, 19 and 22, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Office Manager, the RAI Coordinator, residents' Substitute Decision Makers (SDM) and residents.
During the course of the inspection, the inspector conducted a walking tour of the home, observed resident care and services, reviewed resident health care records, reviewed critical incident reports,, reviewed the fall prevention policy and procedures, and the abuse and neglect policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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. 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 their 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 June 21, 2018:

Definition of verbal abuse: Any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of belittling or degrading nature which diminishes a residents sense of well- being, dignity or self-worth, that is made by anyone other than a resident

Policy: Under no circumstances will abuse and/or neglect of residents be tolerated by anyone. Every incident / suspicion of abuse must be reported, investigated, documented and resolved no matter how insignificant or minor the incident may seem.

Detection and Protection - Staff to Resident:
-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 abused or by other person(s).
-the witness must ensure safety of the alleged victim, and report the incident to the unit nurse immediately.
-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.

Critical Incident System report was submitted to the Director on an identified date, which indicated that on a particular date, PSW #123 had been verbally abusive with resident #005.

On October 15, 2018 PSW #125 advised inspector #531, that on an identified date, they and PSW #123 were providing evening care for resident #005, the resident became aggressive, startling PSW #123, who made an inappropriate comment to the resident. PSW #125 further advised, that they completed resident #005's care, the resident was their usual self, no distress. PSW #125 told inspector #531 that they then needed to respond to another resident and did not report the incident to the unit nurse until the next evening.

During an interview with DOC #101 and the ADOC #129 and review of the critical incident report including investigative documentation, both advised that PSW #125 acknowledged not notifying the unit nurse until the next evening. DOC #101 further advised that PSW #125 was provided education and directed to ensure they immediately report to the unit nurse on duty.

The home's abuse policy specifically stated that every incident/suspicion of abuse must be reported no matter how insignificant or minor the incident may seem; despite this policy direction, a PSW staff failed to immediately report the verbal abuse. [s. 20. (1)]

2. The licensee has failed to ensure that their 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 June 21, 2018:

Definition of verbal abuse: Any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of belittling or degrading nature which diminishes a residents sense of well- being, dignity or self-worth, that is made by anyone other than a resident.

Policy: Under no circumstances will abuse and/or neglect of residents be tolerated by anyone. Every incident / suspicion of abuse must be reported, investigated, documented and resolved no matter how insignificant or minor the incident may seem.

Detection and Protection - Staff to Resident:
-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).
-the witness must ensure safety of the alleged victim, and report the incident to the unit nurse immediately.
-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.
-outside of regular business hours, the after-hours pager must be contacted to notify the

Director at the Ministry of Health.
-Critical incident reports will be completed and submitted by an Assistant Director of Care, Director of Care, or Administrator.

Critical Incident System report was submitted to the Director on an identified date, which indicated that on a particular date PSW #123 had been verbally abusive with resident #011.

On October 15, 2018 RPN #120, advised inspector #531, that on an identified date, they heard resident #011 yelling at PSW #123 at the nurses desk, regarding where their spouse was to be settled for the night; PSW #123 responded in an angry tone that the spouse was also their resident and they had followed the spouse's direction. RPN #120 further advised, that they immediately responded to the voices, found resident #011 standing at the desk alone, and proceeded to discuss the concern with resident #011 and their spouse, and the issue was resolved. RPN #120 completed the internal abuse incident report, reviewed and revised the residents' plan of care, documented the incident in the progress notes, completed the required internal notifications of this to the RN on duty and sent an email notifying the ADOC. RPN #120 indicated PSW #123, had left the building and that management was responsible for following up with the PSW. RPN #120 told inspector #531 that they were not aware they had not contacted the Director until approached by the ADOC on a particular date.

During an interview with DOC #101 and ADOC #129 the critical incident report and investigative documentation were reviewed. The ADOC indicated that they were away and did not receive the email regarding the incident until an identified date, at which time it was noted that RPN #120 had not notified the Director. The DOC #101 and ADOC #129 advised that RPN #120 was re-educated regarding notification practices.

The home's abuse policy specifically stated that every incident/suspicion of abuse that occurs outside of regular business hours, the after-hours pager must be contacted to notify the Director at the Ministry of Health. [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 written policy to promote zero tolerance of a abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse had occurred or may occur, immediately report the suspicion and information to the Director.

On October 15, 2018 RPN #120, advised inspector #531, that on an identified date, they heard resident #011 yelling at PSW #123 at the nurses desk, regarding where their spouse was to be settled for the night; PSW #123 responded in an angry tone that the spouse was also their resident and they had followed the spouse’s direction. RPN #120 further advised, that they immediately responded to the voices, found resident #011

standing at the desk alone, and proceeded to discuss the concern with resident #011 and their spouse, and the issue was resolved . RPN #120 completed the internal abuse incident reports, reviewed and revised the residents' plan of care, documented the incident in the progress notes, completed the required internal notifications of this to the RN on duty and sent an email notifying the ADOC. RPN #120 indicated PSW #123, had left the building and that management was responsible for following up with the PSW. RPN #120 told inspector #531 that they were not aware they had not contacted the Director until approached by the ADOC on a particular date.

During an interview with DOC #101 and ADOC #129 the critical incident report and investigative documentation were reviewed. Both indicated that the Director was not immediately notified. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds that an abuse had or may occur, immediately report the suspicion and information to the Director.

Critical Incident System report was submitted to the Director on a identified date, which indicating that on a particular date, PSW #123 had been verbally abusive with resident #005.

On October 15, 2018 PSW #125 advised inspector #531, that on a particular date, they and PSW #123 were providing evening care for resident #005, the resident became aggressive, startling PSW #123, who made an inappropriate comment to the resident. PSW #125 further advised, that they completed resident #005's care, the resident was their usual self, no distress. PSW #125 told inspector #531 that they then needed to respond to another resident right away and did not report the incident to the unit nurse until the next evening.

During an interview with DOC #101 and the ADOC #129 and review of the critical incident report including investigative documentation, they indicated that the Director was not immediately notified. [s. 24. (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 the the person who has reasonable grounds to suspect that abuse has occurred or may occur, immediately report the suspicion and information to the Director, to be implemented voluntarily.

Issued on this 31st day of December, 2018

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

Original report signed by the inspector.