Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa Service Area Office
347 Preston Street, Suite 420
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Original Public Report

Report Issue Date: November 29, 2022	
Inspection Number: 2022-1385-0001	
Inspection Type: Critical Incident System	
Licensee: Belcrest Nursing Homes Limited	
Long Term Care Home and City: Belmont Long Term Care Facility, Belleville	
Lead Inspector Stephanie Fitzgerald (741726)	**Inspector Digital Signature**
Additional Inspector(s) Amber Lam (541)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 17, 21, and 22, 2022.

The following intake(s) were inspected:
- Intake: #00003705 / CI: 2901-000017-22 Regarding alleged neglect of care to a resident
- Intake: #00005529 / CI: 2901-000018-22 Regarding alleged neglect of care to a resident
- Intake: #00005008 / CI: 2901-000020-22 Regarding alleged staff to resident Emotional Abuse
- Intake: #00008265-2901-000023-22 Fall of resident resulting in transfer to hospital

The following intakes were completed in the Critical Incident System Inspection:

Intake #00004720 / CI: 2901-000010-22 and Intake #00001450 / CI: 2901-000021-22, were related to falls resulting in transfer to hospital.

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

Prevention of Abuse and Neglect
Falls Prevention and Management
Infection Prevention and Control
Safe and Secure Home

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to comply with their policy to promote zero tolerance of abuse and neglect.

Rationale and Summary
The licensee's policy to promote zero tolerance of abuse and neglect defines neglect as 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.

A resident was found to be on their bedpan. Staff members who were working that shift, confirmed to registered staff, that they had not placed the resident on the bedpan. The resident experienced altered skin integrity. During the home's investigations, staff stated they had placed the resident on the bedpan during their shift and had failed to report this to the oncoming shift.

In a second incident, a Resident was found to be on their bedpan, and staff members who were on shift confirmed they had not placed the resident on bedpan. The resident experienced altered skin integrity. During the home's investigation, staff stated they had put the resident on the bedpan during their shift and had failed to report this to next shift.

The licensee confirmed that the resident was neglected by being left on the bedpan, and follow up action was taken with staff involved in the incidents. The licensee failed to prevent the resident from neglect, and therefore, did not comply with their policy to promote zero tolerance of abuse and neglect.

Sources: Investigation notes, interview with Director of Care, resident's health care record and the licensee's policy "Abuse policy" #ADM-VI-06.
[541]

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WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors which led to the non-residential areas of the home were kept closed and locked when they are not being supervised by staff.

Rationale and Summary:
On November 17th, and November 21st, 2022, Inspector observed six doors to non-residential areas were left open. The doors were located among the Streamway Unit, Montgomery Unit, and Belcrest Unit. On one occasion, at the time of the observation, there was noted to be one resident in the immediate surroundings. The doors led to the clean utility, dirty utility, and storage areas. Staff could not be found inside the room, or the immediate vicinity of the room, leaving them unattended and unsupervised. Staff members confirmed the doors should not be left open and closed them. By not ensuring that all doors leading to non-resident areas of the home were kept closed and locked, unsupervised residents may have had an opportunity to wander into the non-resident area, posing risk of injury.

Sources: Observations occurring on November 17 and 21, 2022, Interviews with DOC, and other staff.
[741726]

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 (2) (b)

The licensee has failed to ensure that a standard issued by the Director, with respect to support for residents to perform hand hygiene prior to receiving meals, was complied with. In accordance with additional requirement 10.4 h). under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022), the Licensee shall ensure that the hand hygiene program also includes support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

Rationale and Summary:
Inspector observed staff assisting two residents to the dining room for meal service. The staff member was observed seating both residents. Hand hygiene was not offered to either resident upon entry, or

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once seated, prior to meal service at the table. A sign was noted outside of the dining room, which indicated, "Please be sure resident and staff hands are cleaned with hand sanitizer when entering the dining room prior to meal". Interviews with staff confirmed hand hygiene should be offered prior to entry to the dining room for meals or offered at the table for wheelchair dependent residents. By not ensuring support for hand hygiene was offered prior to meal service, there was a risk of illness and infection to the residents.

Sources: Observations of meal service, Interviews with DOC and other staff.
[741726]

WRITTEN NOTIFICATION: Directives by Minister

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home (LTCH) to carry out every operational directive was complied with.
In accordance with section 1.1 of the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee was required to ensure that the LTCH was conducting regular Infection prevention and Control (IPAC) audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended.

Rationale and Summary:
Interviews with IPAC Lead and DOC confirmed that IPAC self-audits for the LTCH were not being completed every two weeks. A review of a binder labelled "Self-Assessment Audits Q2Weeks" had record of self-audits completed on March 21, 2022, June 2, 2022, July 14, 2022, August 2, 15, 18 2022, Sept 01, 2022, and October 28, 2022.
The Licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when they did not complete IPAC audits every two weeks. By not ensuring measures are taken to prepare for and respond to a COVID-19 outbreak, there was a risk of illness to the residents.

Sources: Record Review of IPAC Self-Audits, Interviews with IPAC Lead and DOC.
[741726]