Ontario

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

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: June 14, 2023	
Inspection Number: 2023-1385-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Belcrest Nursing Homes Limited	
Long Term Care Home and City: Belmont Long Term Care Facility, Belleville	
Lead Inspector Cathi Kerr (641)	**Inspector Digital Signature** Cathi Kerr Digitally signed by Cathi Kerr Date: 2023.06.19 14:23:39 -04'00'
Additional Inspector(s) Patricia OBrien 000730)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 16, 17, 18, 19, 2023

The following intake(s) were inspected:

- Intake: #00021290 - Fall of a resident resulting in an injury.
- Intake: #00084504 - Staff to resident alleged neglect.
- Intake: #00086634 - A complaint related to resident care and services.
- Intake: #00087709 - Related to resident care and services.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the safety /clip alarm was on a resident while in bed as outlined in the plan of care.

Rationale and Summary:

A resident sustained an injury after falling in their room. The resident's care plan identified the use of a safety/ clip alarm while in bed.

The resident was observed by Inspector #000730 on three occasions during the inspection to be lying in bed without the safety/clip alarm available in the room and attached to the resident, as directed in the resident's care plan.

The Director of Care, PSW #110 and other staff confirmed that the safety/ clip alarm should be on the resident at all times, while in bed. Failing to ensure the resident's safety /clip alarm is attached to the resident as directed in the plan of care, puts the resident at risk for falls.

Sources: Interviews with the Director of Care, PSW #110 and other staff, observations of the resident and plan of care. [000730]