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
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Original Public Report

Report Issue Date: July 26, 2023	
Inspection Number: 2023-1385-0004	
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: 2023.08.04 16:39:14 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 11, 12, 13, 14, 18, 19, 20, 2023

The following intake(s) were inspected:

- Intake: #00089761 - CIS #2901-000016-23 related to a skin and wound injury.
- Intake: #00091416 - CIS #2901-000021-23 related to a skin and wound injury.
- Intake: #00091548 - a complaint related to resident care concerns.
- Intake: #00091752 -CIS #2901-000022-23 related to resident care.
- Intake: #00091781 - a complaint related to resident care.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutrition and Hydration

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

The licensee failed to ensure that the resident's written plan of care indicated the requirement for adaptive drinking cups.

Rationale and Summary:

During an interview with Inspector #641, the Nutritional Care Manager (NCM) indicated they implemented the use of adaptive cups for all fluids for the resident. Interviews with registered nursing staff and PSWs indicated they were aware that the resident was to receive their fluids with an adaptive cup to make it easier for the resident. They indicated that they didn't always have the cups available and would sometimes use a large mouth cup or administer the fluids with a spoon.

Inspector #641 observed on three occasions throughout the inspection that the resident had regular drinking cups and not adaptive cups for their fluids. A review of the resident's care plan didn't specify the use of adaptive drinking cups for all fluid intake. This was added to the care plan later during the inspection.

Failure to identify adaptive cups in the resident's plan of care put the resident's nutrition and hydration at increased risk.

Sources: resident's care plan; interviews with the DOC, RPNs and PSWs; and observations of the resident. [641]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 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 care set out in the plan of care for the resident was provided to the resident as specified in their plan.

Rationale and Summary:

The resident's care plan indicated that the safety bed pad alarm was to be in use when they were in bed and to hang the monitor on the outside of the door to alert staff when the resident was up from the bed. Inspector #641 observed the monitor for the bed pad alarm to be hanging beside the resident's bed on two separate days during the inspection.

During an interview with the Inspector, the Director of Care (DOC) stated that when they had become aware that the monitor for the bed pad alarm was not hanging on the resident's door, they had put a note in the maintenance book for a hook to be placed on the resident's door. When this had not been done three days later, the DOC moved the alarm from beside the resident's bed to outside of their room, as directed by the care plan. An RPN and PSW stated during interviews with the Inspector, that the resident's bed alarm monitor should be hanging on the door outside of the room and they were not aware why it would be hanging in the resident's room beside the bed.

Failure to follow the resident's plan of care put the resident at increased risk for falls as it would be more difficult for the staff to hear the alarm.

Sources: resident's care plan; interviews with the DOC, RPN and PSW; and observations of the resident's room. [641]

WRITTEN NOTIFICATION: Continence Care and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee failed to ensure that the resident's individualized plan of care related to continence was implemented.

Rationale and Summary:

Inspector #641 observed the resident's electronic health care record, specifically Point of Care charting. There was one documentation of a continence check during an eight hour period on a specified date.

The resident's care plan indicated that staff were to follow the toileting routine as defined in the resident's care plan.

During interviews with Inspector #641, the DOC, RPN and PSWs indicated that all residents were to be checked for continence before and after meals, before any naps and before bedtime. Another PSW indicated they would not check the resident for continence when the resident's family were present in the room as the family member would ring to alert them that the resident needed assistance.

Failure to follow the resident's plan of care for continence put the resident at increased risk for discomfort and skin breakdown.

Sources: resident's care plan; interviews with the DOC, RPN and PSWs; and Point of Care documentation. [641]