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: September 27, 2023	
Inspection Number: 2023-1385-0005	
Inspection Type: Complaint Critical Incident/Complaint	
Licensee: Belcrest Nursing Homes Limited	
Long Term Care Home and City: Belmont Long Term Care Facility, Belleville	
Lead Inspector Wendy Brown (602)	**Inspector Digital Signature** Wendy K Brown Digitally signed by Wendy K Brown Date: 2023.09.29 15:34:53 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 5 - 8, 2023

The following intake(s) were inspected:

- Intake: #00094373/CIS #2901-000024-23 - Complaint regarding improper care leading to fall.
- Intake: #00095195 - Complaint regarding improper care specifically oral, nutrition, resident rights and hs care.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

The licensee failed to ensure that a resident's written plan of care set out clear direction to staff and others who provide direct care to the resident.

Rationale & Summary:
A resident's care plan and direction in point of care (POC) outline that oral/mouth care is to be provided three times a day, after each meal. Direct care staff indicated that the resident's Power of Attorney (POA)/family and the Director of Care (DOC) advised differently indicating that oral care was to be provided twice a day. Signage also indicated that mouth care was to be provided twice a day.

In addition, the resident's POA/family was informed that oral care using toothpaste and mouthwash was unsafe due to aspiration/choking risks and was advised that a thickened mouth gel should be used. Interviews indicated that the gel had recently been replaced by regular mouthwash and toothpaste. The POA/family was not contacted as to the reasons for this substitution.

Unclear direction regarding mouth/oral care could place residents at an increased risk for aspiration/choking and poor oral hygiene possibly resulting in respiratory and/or oral cavity deterioration.

Sources:
Resident care plans, emails exchanges, bathroom observations and interviews with the POA, direct care staff and the DOC. [602]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that a resident's POA/family was given an opportunity to participate fully in the development and implementation of the plan of care.

Rationale & Summary:

Diet texture - The POA/family noted that the resident received thickened beverages; they contacted the Dietary Manager (DM) for clarification. The DM advised that staff had previously noted the resident was coughing on thin fluids and having difficulty chewing regularly textured food; the resident was subsequently referred to the Registered Dietician (RD) for assessment. The resident was then trialed on a modified texture diet and thick fluids. The POA/family were not notified of the change in status, the trial, and/or the dietary changes. In interviews a, Registered Practical Nurse (RPN) and the RD confirmed that current procedure outlined that POAs/families should be alerted to dietary order changes after the change was completed.

Supplement – A resident's POA/family noted that they consented to a change in care plan allowing the provision of a supplement to the resident, three times a day, during the medication pass. The POA/family were assured that the RD would assess the resident with respect to provision of the supplement the following day; a referral was not completed and this was not done. The POA/family contacted the DM the following month to clarify why this had not been implemented and was told that the DM they remembered the earlier communication and assumed the answers "were never provided" to the POA/family. A diet order for the supplement was added to the plan of care approximately two months after the initial agreement.

Positioning – A resident's POA/family asked that the resident be placed on their side when assisted to bed; they had requested this previously given the residents historical preference for this position and concerns regarding coughing and choking risks, however, they later noted the resident was still being placed in bed on their back. The DOC indicated that staff advised the resident rolls onto their back when placed on their side and that they cannot prop pillows behind them to prevent rolling over as this could be considered a restraint. Potential positional aids were not reviewed, the concern was not resolved and direction re bedtime (hs) positioning has not been included in the plan of care**.**

Sling - A resident's POA/family indicated that it had been decided that the resident's transfer sling would not be left on the resident's wheelchair for multiple reasons including safety and comfort. Despite this agreement the POA/family noted that the sling was commonly left on the wheelchair under the resident and asked the DOC to follow-up. After investigation the DOC advised the POA/family that it had become unsafe to remove the sling as the resident was stiff and less likely to assist in it's removal posing the risk of injury to the resident and staff. Concerns regarding the resident's comfort and safety while seated have not been addressed and direction as to removing the sling have not been included in the plan of care.

Hs care - The POA/family noted that despite multiple requests the resident was not regularly being assisted to don their pajamas at hs. The resident regularly wore pajamas to bed prior to moving to the Long-Term Care home as they often got cold during the night. On inquiry the DOC cited various reasons for not including the donning of pajamas at bedtime in the resident's plan of care including: potential resistive behaviours, fall risk (may try to remove their pajama bottoms and fall out of bed) as well as heat risk.

During this inspection the following addition to the resident's care plan was made: "provide specific hs routine. Clean PJ top and bottom at bedtime Please document if there is any resistance, signs of heat issues or if resident is attempting to remove", there was no discussion with the POA/family re initial rejections of the request or eventual inclusion within the plan of care.

Failure to provide the POA/family to opportunity to participate in the planning an implementation of the plan of care could place the resident's health, safety, comfort and right to choose at risk.

Sources:
Multiple email exchanges, Diet Orders, Diet order Policy& Procedure, resident progress notes, care plans, and interviews with the POA/family, the DOC, DM, a RPN and the RD. [602]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in a resident plan of care specific to the provision of a specific beverage and closing the resident's door was provided as specified in the plan.

Rationale & Summary:
The RD indicated in a progress note that the POA/family requested that specific beverage no longer be offered to the resident, with the exception of breakfast, due to concerns regarding various health conditions. The POA/family shared their concern that although the DM indicated this direction had been implemented, it was not being done consistently. The DOC and PSW staff indicated that the specified beverage had been provided, on occasion, at lunch and at snack times subsequent to the POA/family's request. During this inspection the DOC added a note to the dietary cart and met with direct care staff to remind them that the beverage is only to be provided at breakfast.

In an interview the POA/family advised they have requested that the resident's door be closed on multiple occasions since their admission. The DOC confirmed that there have been numerous communications to this end and that the plan of care and signage on the door outline this direction. During this inspection observations and interviews with direct care staff revealed that the door is often left open/partially open.

Disregarding direction in the plan of care could put the resident's health and right to privacy at risk, respectively.

Sources:
Resident plan of care, RD progress note, care plan, assessment documentation, observations during inspection and interviews with the POA/family, PSWs, a Registered Practical Nurse, the RD and DOC. [602]