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

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# Original Public Report

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| Report Issue Date: December 4, 2024 |
| Inspection Number: 2024-1385-0006 |
| Inspection Type:<br>Critical Incident |
| Licensee: Belcrest Nursing Homes Limited |
| Long Term Care Home and City: Belmont Long Term Care Facility, Belleville |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 26-29, 2024 and December 2-3, 2024.

The following critical incident intake(s) were inspected:
Intake: #00129219/CIS2901-000057-24- related to alleged staff to resident neglect.
Intake: #00129266/CIS2901-000058-24 - related to alleged resident to resident verbal and physical abuse.
Intake: #00133016/CIS2901-000061-24 - related to the fall of a resident resulting in an injury.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident was given an opportunity to participate fully in the development and implementation of their plan of care, when a member of the staff did not contact the police to report an allegation of assault as requested by the resident.

Sources: Review of progress notes, interview of Director of Care (DOC), a member of the staff and the resident.

## WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that developed strategies were implemented to respond to a resident's demonstrated responsive behaviours.

Specifically, the Collaborative Care Meeting minutes indicated the use of a specific strategy in response to the resident's demonstrated responsive behaviour.
Review of the resident's health records, indicated that the specific strategy was not implemented.

Sources: Observation of strategies specific to responsive behaviour, review of the health care record, the Collaborative Care Meeting minutes and interview with the DOC and other staff.

## WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that for a resident's demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including documentation within the resident's health care record to support the use of, or the resident's response to, a specific intervention.

Sources: Review of the resident's electronic and hard copy health records, interview with the DOC and other staff.

## WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 112 (3)
Licensees who report investigations under s. 27 (2) of Act
s. 112 (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

The licensee has failed to provide the final report to the Director within a period of time specified by the Director.

A critical incident system report was submitted related to an alleged incident of staff to resident neglect. The licensee's investigation was not completed and thus, the licensee failed to provide a final report to the Director.

Sources: Review of the CIS report, the licensee's investigation documents, interview with the DOC.

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed of an injury for which a resident was taken to the hospital and that resulted in a significant change in the resident's health condition no later than one business day. Specifically, on a specified date, a resident had a fall which resulted in injuries and a significant change in status. The incident was first reported to the Director six business days later.

Sources: Resident's progress notes, CIS report, and an interview with the DOC.