Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 15, 2014	2014_348143_0006	O-000348-14	Resident Quality Inspection

Licensee/Titulaire de permis

BELCREST NURSING HOMES LIMITED
250 Bridge Street West, BELLEVILLE, ON, K8P-5N3

Long-Term Care Home/Foyer de soins de longue durée

Belmont Long Term Care Facility
250 Bridge Street West, BELLEVILLE, ON, K8P-5N3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PAUL MILLER (143), AMBER MOASE (541), GWEN COLES (555)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 28th, 29th, 30th, May 1st, 2nd, 5th, 6th, 7th and 8th, 2014.

Critical Incident Inspection log # O-000116-13 was also inspected during the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Owner/Operator, the Administrator, the Acting Director of Care, two Assistant Directors of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), an attending Physician, the Environmental Service Manager, housekeeping staff, maintenance staff, the Food Service Supervisor, a Registered Dietitian, a Physiotherapist, a Physiotherapy Assistant, Activation staff, a Restorative Care Aide, the President of the Resident Council, residents and family members.

During the course of the inspection, the inspector(s) completed tours of all resident home areas, observed resident dining service, medication administration, observed resident care and services, reviewed policies and procedures, monitored hot water temperatures, reviewed infection control practices, staffing schedules, minutes from Resident Council meetings and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with Ontario Regulation 79/10 section 90.(2)(g) by failing to ensure Water Temperature Procedure Policy # ENV S.4-0430 is implemented by not ensuring that water temperatures serving all bathtubs, showers and hand basins used by residents does not exceed 49 degrees Celsius (C).

On May 2nd 2014, at 0200 hours staff recorded a temperature of 64 degrees C in room 112. On May 3rd, 2014 night staff recorded a temperature of 60 degrees C in room 16. On May 4th room 113 had a recorded temperature of 61 degrees C during the night shift (2400-0800). On May 5th at 0950 hours room 16 had a recorded temperature of 55 degrees C, room 115 had a recorded temperature of 52 degrees C during the evening shift and room 102 a recorded temperature of 65 degrees C. On May 7th room 114 had a recorded temperature of 63 degrees C at 2450 hours. On February 9th room 137 had a recorded temperature of 64 degrees C. [s. 90. (2) (g)]

2. The licensee has failed to comply with O. Reg 79/10 section 90.(2)(h) by not ensuring that immediate action is taken to reduce water temperatures that exceed 49 degrees Celsius.

On May 2nd 2014 room 112 had a recorded temperature of 64 degrees C at 0200 hours. As per the homes water temperature policy:
Procedure 2. Water temperature will be checked each shift by a Health Care Aid (PSW).
Procedure 4. If the temperature is above or below the range, report to charge Nurse immediately who will report this to the Maintenance Supervisor or delegate. The Environmental Service Manager will check the source temperature, take corrective action as necessary and document action taken in water temperature books with date and time actions taken. This may include calling the plumber and or electrician.

This hot water temperature of 64 degrees C recorded was not reported to the RN and no immediate action was taken.
On May 3rd, 2014 during the night shift room 16 (bathroom) had a recorded temperature of 60 degrees C. This was not reported to the RN and the action taken was to place a sign in the bathroom indicating "Caution hot water". [s. 90. (2) (h)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The Licensee has failed to comply with Ont.Regulation 79/10 section 36 by not ensuring that staff use safe transferring techniques.

The following finding is related to Critical Incident Inspection log # O-00116-13:

On a specified date staff(S) S120 (PSW) assisted resident #4537 with continence care. Resident #4537 stood at the sink with her/his wheelchair positioned behind her/him. S120 was present in the resident bathroom standing behind the wheelchair. Resident #4537 fell and sustained an injury. S120 was not able to prevent the fall as she/he was not in a position to assist the resident from falling. The resident was transferred to hospital and returned to the home from the hospital on the same day of the incident. The home's management staff submitted a Critical Incident Mandatory report to the Ministry of Health indicating improper/incompetent treatment of a resident that resulted in harm or risk to a resident. The home's internal investigation into the incident indicated that the staff used improper transferring techniques. S120 received disciplinary action as well as a requirement to attend training on transferring techniques.
On a specified date S120 was observed transferring resident #1 without a spotter (additional staff). A review of the plan of care for resident #1 indicated that in order to assist with transfer from one position to another provide 2 persons with the use of a mechanical lift. S120 received disciplinary action related to this incident.
On a specified date S120 was observed to have transferred resident #4563 with a mechanical lift with no additional staff. Resident #4563's plan of care indicates that the resident is to be transferred from one position to another by 2 staff with physical assistance of a mechanical lift. The homes internal investigation into this incident indicated that S120 actions put the resident at risk. S120 received progressive discipline in respect of this last incident. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct resident care receive training in safe transferring techniques, review appropriate polices and procedures and provide care as per the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The Licensee has failed to comply with Ont.Regulation 79/10 section 229.(2)(e) by not ensuring that a written record is kept that evaluates the Infection Prevention and Control Program (IPCP).

On May 7th, 2014 Inspector #143 interviewed S104 who is the designated staff member who co-ordinates the IPCP. A request was made by the inspector to review the written record that includes the date of evaluation, names of the persons who participated in the evaluation as well as the summary of the changes made and dates that the changes were implemented. S104 informed the inspector that the home did not have any such record. The Administrator and the Acting Director of Care

confirmed on May 8th, that the home does not have this record and that the program is evaluated on an informal basis. [s. 229. (2) (e)]

2. The Licensee has failed to comply with Ont. Regulation 79/10 section 229.(3) by failing to ensure that the staff member who co-ordinates the IPCP has education in infection prevention and control practices.

On May 7th, 2014 S104 was interviewed by Inspector #143. S104 informed the inspector that she has been the infection control lead for almost a year. Inspector #143 questioned S104 if she had completed any courses in infection control or completed any education in respect of infectious diseases, data collection and trend analysis and cleaning and disinfection. S104 reported that she had not completed any ICPP courses but had completed a mandatory just clean your hands program. On May 8th, 2014 both the Administrator and the Acting Director of Care reported to the inspector that S104 lacks education in infection control. [s. 229. (3)]

3. The licensee failed to comply with Ont.Regulation 79/10 section 229.(4) by failing to ensure that all staff participate in the implementation of the infection prevention and control program.

On May 5, 2014 at 12:00 hours Inspector #555 observed 3 medication passes on Green Acres with S111 and observed no hand hygiene done between medications passes. Inspector #555 interviewed S111 who reported that the expectation is for hand hygiene to be done prior to starting medication administration and after touching client skin and that it is not necessary to perform hand hygiene if using utensils or not touching residents directly. At 12:20 Inspector #555 observed 2 oral medication passes on Streamway Unit with Staff #108 and observed no hand hygiene being performed between medications passes. S108 reported the expectation is to perform hand hygiene between medications passes. Interview with S102 at 14:00 who reported the expectation is for hand hygiene to be done between each medication pass.

Review of "Hand Hygiene Requirements" included in the "Infection Control Manual INF-II-30" indicated hand washing is to be done "before and after performing a nursing procedure involving resident contact"; and "before preparing or administering medication by any route"; and "before initial resident/resident environment contact". Staff failed to follow the implementation of the infection prevention and control program. [s. 229. (4)]

4. The licensee failed to comply with Ont. Regulation 79/10 section 229.(10)(4) by not ensuring that staff are screened for tuberculosis (TB) and other infectious diseases.

On May 7th, 2014 Inspector #143 questioned S104 in respect of screening staff for TB. S104 informed the inspector that she was unaware of screening staff for infectious diseases. A request was made to review recent hired staff infectious diseases screening and was advised that S113 (PSW), S136 (PSW) and S137 were not screened for infectious diseases. [s. 229. (10) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the hand hygiene program, that the staff member who co-ordinates the Infection Prevention and Control Program (IPCP) receives training in infection prevention and control, staff are screened for Tuberculosis and other infectious diseases as well that the home complete an annual evaluation of the IPCP, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007 c.8 s.3(1).1 whereby the licensee has not fully respected and promoted the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

On a specified date while conducting an interview with resident #4546 in her/his room with the door closed, Inspector #555 observed three staff members enter the resident's room on three occasions without knocking. When asked by Inspector #555 if this is common practice, resident #4546 indicated that this happens often.

On a specified date while conducting an interview with resident #4565 in her/his room with the door closed, Inspector #541 observed staff member S121 enter the residents room and leave without speaking to the resident.

On a specified date Inspector #143 observed staff member S107 enter two resident rooms without knocking.

On a specified date resident #4571 reported to Inspector #541, when asked if he/she is treated with dignity and respect, replied no, indicating that staff were rushed while providing his/her care.

On May 8th, 2014 the Administrator reported to Inspector #143 that it is the expectation that staff knock or request permission to enter a residents room. The Administrator indicated that it is common courtesy to request permission to enter a residents room. [s. 3. (1) 1.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with Ont.Regulation 79/10 section 8.(1) by not ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is: (a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and (b) complied with.

Ont.Regulation 79/10 section 114.(2) states the following:
The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

1.A review of the Resident Care and Services Manual - Self Administration of Medications Index I.D:RCSM-F-40 dated January 14, 2014 indicated the following policy statements:
There must be a safe and secure place, away from other residents, to store the medication supply.
A physician's order is required for the administration of medications including self administration.
The Home Unit Nurse will assess the resident's ability to self administer using the Self Medication Assessment tool and will provide ordered medications to the resident for self-administration. This assessment to be completed with the original order, quarterly and following any significant change in the resident's health status.

On a specified date Inspector #555 interviewed Resident #8. Resident #8 reported that she/he self-administers medications. Inspector #555 observed that medications were placed on top of a night table. It was observed that the room currently had a wander guard strip in place and the resident indicated that occasionally other residents will attempt to wander into her/his room. The resident is aware of the use of

medications and related dosages and reports that she/he did not sign any document in respect of a self-medication assessment (self Administration of Medications tool (RCSM F-41). At a specified time Inspector #555 observed medications stored on night table and resident and roommate were not present in room and that a wander guard strip was in place. A review of the physician orders for resident #8 dated on a specified date indicated that a current order for the resident to self medicate was not completed.

On a specified date Inspector #555 interviewed Resident #10 who reported that she \he self-administers medications. Inspector #555 observed 2 bottles of medications stored on top of a dresser in a small dish. Inspector #555 reviewed Resident #10's physician orders and confirmed that an order for self-administration was in place. The Resident was aware of the use of the medication and related dosage but denied signing the self medication assessment tool (RCSM-F-41) documentation related to self-administration of medications, and denies having a safe and secure place to store the medication supply. The resident preference is to have the medications placed on top of her\her dresser so that she\he does not forget to administer them. The resident reports there is another resident who will wander into her\his room periodically.

On a specified date S102 reported to Inspector #555 that she\he was aware of Resident #8 keeping inhalers at bedside. S102 reported that the wander guard strip is in place due to residents wandering on unit. S102 reports Resident #8 has no cognitive issues and is aware of usage of medications. S102 denies any concerns about safety of medication storage from other residents as resident and roommate do not like residents in room and that Resident #8 takes the medication with her\him when she\he leaves the room. On May 5th, 2014 S103 who reported to the inspector that there is no self- administration form on file for Resident #8 or Resident #10. On May 6th, 2014 S103 informed the inspector that the home has now completed the Self medication assessment tool (RCSM-F-41) for resident #8 and #10. S103 advised the Inspector #555 that she\he has spoken to residents about safekeeping of medications.

S103 reported that there is no order on file for self-administration for Resident #8. S103 reported medication being left on night table or dresser top is not considered safe and secure due to wandering residents on units.
The licensee has failed to comply with their policy but not ensuring that an order is obtained for residents to self medicate and by not completing the self medication assessment tool (prior to this inspection).

2. A Review of Policy entitled "Safe Storage of Medications" 4.8 dated October 2010 indicated the following:
All medications are stored in a locked medication room, cupboard, or cart and keys to access these areas must be in the possession of a person with authority to dispense, prescribe or administer drugs in the home, or the Administrator at all times.

On May 5th, 2014 at 11:45 Inspector #555 observed that the Montgomery medication room door was left open and unattended with no registered staff at nursing station. This medication room contained unsecured government stock medications, open medication disposal container with medications in it and a secured medication cart. The Inspector remained present until Staff #119 arrived, the door was then secured and locked. S119 reported the expectation is for medication room doors are to be closed and locked when registered staff are not in attendance.
The licensee failed to comply with the policy related to Safe Storage of Medications.

3. A review of Belmont Long Term Care Facility - Delegation of Function/HCA, PSW, Students policy states the following:
The following procedures/practices will be reviewed on orientation and annually for each HCA, PSW and Student employed at Belmont Long Term Care Facility: Function - 1. Application of Prescription Shampoos/Ungt/Cream/Lotion.

On May 5th, 2014 S102 reported to Inspector #555 that PSW's do administer topical medications. S102 reported that the administration of topical medication is an annual mandatory training for PSW staff but there are no records available for 2012 and no annual training completed in 2013.
The licensee failed to follow the policy related to Delegation of Function/HCA, PSW, Students in respect of the administration of topical medications. [s. 8. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.26(3)21 in that the plan of care was not based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

During an interview with Inspector #541 when asked if she\he participates in choosing when to get up in the morning, resident #4530 indicated she\he would like to sleep in but has to get up if she\he wants to eat. Resident #4565 indicated she\he would prefer to get up at 7am but staff get her\him up at 6 am.

The care plan for resident #4530 effective April 30, 2014 was reviewed on May 6, 2014 and it does not reflect the resident's preference of time to get up in the morning. The care plan for resident #4565 effective January, 2014 was reviewed on May 6, 2014 and it does not reflect the resident's preference of time to get up in the morning.

On May 6, 2014 during an interview with inspector #541, S115, S112 and S113 all indicated resident preference of time to get up in the morning are not indicated in the care plan. [s. 26. (3) 21.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The Licensee has failed to comply with Ont.Regulation 79/10 section 31.(4)(e) by not ensuring that a written record is completed in respect of evaluating the staffing plan.

On May 7th, 2014 the Administrator and the Acting Director of Care informed Inspector #143 that the home does not have a written record of each evaluation of the staffing plan. The Acting Director of Care reported that the evaluation is completed informally. The Administrator presented attendance records with dates that changes had been made to the nursing and personal support schedules. The Administrator reported that she was not able to provide the dates of the staffing evaluation and the names of the persons who participated in the evaluation. [s. 31. (4)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The Licensee has failed to comply with O.Reg 79/10 section 50.(2)(b)(ii) by not ensuring that residents with altered skin integrity receive immediate treatment and interventions to promote healing.

Resident #4589 was observed on a specified date to have scratches on his\her left foot. On May 2nd, 2014 S106 (RPN) reported to inspector #143 that resident #4589 has dry itching skin and often will scratch himself\herself. A review of the Treatment Administration Record (TARS) indicates that the resident is to receive a medicated cream to the affected areas twice daily. The TARS indicated that the resident is to receive this treatment twice a day and coded a 10 (PSW/HCA Applied). A review of the May 2014 TAR indicated that the 0600 entry for May 1st and 2nd had no documentation indicating that the treatment had been applied as ordered. S106 completed a search of the treatment administration cart as well as the medication administration cart and resident room and reported to the inspector that the medicated cream was not available for application. S107 (PSW) completed a room search and reported to the inspector that the medicated cream was not in the residents room. A review of the April 2014 TARS indicated that on twenty six occasions the medicated cream was not documented as given. [s. 50. (2) (b) (ii)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to comply with the Long-Term Homes Act section 57.(2) by not responding in writing within 10 days of receiving from the Residents' Council (RC) a concern or recommendations.

On October 16, 2013 the RC held a meeting and raised concerns in respect of staff shortages and the lack of hot water. The Licensee signed response was dated October 28, 2013. On November 13, 2013 the RC raised concerns about hot water temperatures, meals and staff not wearing name tags. On December 12th, 2013 the Licensee provided a response to these concerns. [s. 57. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with Ont.Regulation 116(3) by not ensuring that the medication management system is evaluated annually.
On May 7th, 2014 Inspector #143 interviewed the Administrator (S101) and the Acting Director of Care (S102) in respect of the medication management system. S101 and S102 reported that the home does not use an assessment instrument to evaluate the medication management system. S101 and S102 reported to the inspector that quarterly evaluations as well as annual evaluations of the medication management are not completed. In addition to this S101 and S102 were unable to identify changes to improve the medication management system in accordance with evidence-based practices and or in accordance with prevailing practices. [s. 116. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to comply with Ont.Regulation 79/10 section 130.(1) by not ensuring that all areas where drugs are stored are kept locked at all times, when not in use.

On May 5th, 2014 at 1140 hours Inspector #555 observed a medication room door left open on first floor Montgomery unit. This medication room was left unattended. The medication room contained unsecured government stock medications, an open medication disposal container with medications in it, and a secured medication cart. Inspector #555 remained present until S119 arrived (approximately at 1145 hours) door was then secured and locked. S119 reported that it is the expectation for medication room doors to be closed and locked when registered staff are not in attendance. [s. 130. 1.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee failed to comply with Ont.Regulation 79/10 section 131.(7)(a) by not ensuring that a resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except,
(a) As authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident

On May 5th, 2014 Inspector #555 observed in Resident #8's room that medications were stored on top of the night stand as well as in a drawer of the night stand. The resident resided in a semi-private room with a roommate and had a wander guard strip in place. On a specified date Inspector #555 observed medications stored on the night table while Resident #8 was not present in the room. Interview conducted with Resident #8 who reported she\he self-administers medications these medications, was aware of use and dosages of the medications and denied signing any documentation regarding self-medication assessment (as per policy RCSM-F-40 and RCSM-F-41 dated January 14th, 2014). A review of the physician orders indicated that no orders had been written in respect of the resident being able to self administer medications.

On May 6th, 2014 S103 confirmed with Inspector #555 that a physician or a registered nurse in the extended class had not authorized Resident #8 to administer a drug to herself\himself. [s. 131. (7)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).
2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).
3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).
4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).
5. The reason for destruction. O. Reg. 79/10, s. 136 (4).
6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).
7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

Findings/Faits saillants :

1. The licensee failed to comply with Ont.Regulation 79/10 section 136.(4)(1) and (8) by not ensuring that where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy provides that the applicable team document the following in the drug record:
1. The date of removal of the drug from the drug storage area
8. The manner of destruction of the drug?

A review of the Clinical Pharmacy Services Policy entitled "Medication Disposal 5.8 dated October 2010" and "Medication Disposal - Narcotics/LTCH's 5.8.1 dated October 2010" indicated no reference was made related to the requirement to document the date of removal of the drug from the storage area and the manner of the destruction of the drug. [s. 136. (4)]

Issued on this 16th day of May, 2014

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PAUL MILLER (143), AMBER MOASE (541), GWEN COLES (555)
Inspection No. / No de l'inspection :	2014_348143_0006
Log No. / Registre no:	O-000348-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 15, 2014
Licensee / Titulaire de permis :	BELCREST NURSING HOMES LIMITED 250 Bridge Street West, BELLEVILLE, ON, K8P-5N3
LTC Home / Foyer de SLD :	Belmont Long Term Care Facility 250 Bridge Street West, BELLEVILLE, ON, K8P-5N3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Denise Mackey

To BELCREST NURSING HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee will ensure that:
1. Immediate action is taken to reduce hot water temperature in the event that it exceeds 49 degrees Celsius.
2. All applicable staff are provided training to ensure that the home's policy # ENV S.4-0430 Water Temperature Procedure is followed.

Grounds / Motifs :

1. The Licensee has failed to comply with O. Reg 79/10 section 90.(2)(h) by not not ensuring that immediate action is taken to reduce water temperatures that exceed 49 degrees Celsius.
On May 2nd 2014 room 112 had a recorded temperature of 64 degrees Celsisus at 0200 hours. As per the homes water temperature procedure: (Policy #ENVs.4-0430) the following procedures indicate that:
Procedure 2. Water temperature will be checked each shift by a Health Care Aid in each unit, at random times. This is to be recorded in the water temperature book for that unit.
Procedure 4. If the temperature is above or below the range, report to charge Nurse immediately who will report this to the Maintenance Supervisor or delegate. The Environmental Service Manager will check the source temperature, take corrective action as necessary and document action taken in water temperature books with date and time actions taken. This may include calling the plumber and or electrician.
The hot water temperature taken on May 2nd of 64 degrees C was not reported to the Registered Nurse and no immediate action was taken.
On May 3 during the night shift room 16 (bathroom) had a recorded temperature of 60 degrees C. This temperature was not reported to the RN and the action taken was to place a sign in the bathroom indicating "Caution hot water". (143)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 04, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 15th day of May, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PAUL MILLER

Service Area Office /
Bureau régional de services : Ottawa Service Area Office