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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 26, 2015	2015_347197_0004	O-000664-14	Critical Incident System

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

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

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

JESSICA PATTISON (197), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 21, 22, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and family members of residents.

The inspector(s) also observed resident care and reviewed a resident's health care record and an internal investigation file.

The following Inspection Protocols were used during this inspection:
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6(1)(a) in that the home did not ensure that there was a written plan of care that sets out the planned care for a resident in relation to responsive behaviours.

On a specified date, it was reported to the Administrator that Resident #1 alleged that staff had been rude and treated the resident roughly during care. Upon review of the home's internal investigation file, it was noted that the allegation of abuse was unfounded.

Upon review of Resident #1's health care record it was noted that Resident #1 has a history of certain behaviours towards staff and related to their care.

Resident #1's care plans and RAI MDS (quarterly) assessments were reviewed over a specified period of time. Three of the assessments reviewed indicated that Resident #1 was having behavioural symptoms. Written strategies for managing Resident #1's behavioural symptoms were not included in Resident #1's care plan until five months after the resident was assessed as showing these behaviours.

During an interview with Inspector #602 on January 21, 2015, staff members #S100 and #S101 noted that the resident does show certain behaviours towards staff and at particular times during care.

During an interview with Inspector #197 on January 21, 2015, staff member #S102 confirmed that Resident #1 has shown certain behavioural symptoms since admission and acknowledged that these symptoms had worsened.

On January 22, 2015 during an interview, the Administrator and ADOC confirmed that although the resident has a history of certain behaviours, written approaches and strategies related to these behaviours were not included in writing in Resident #1's care plan until five months after the resident was assessed as showing these behaviours. (602) [s. 6. (1) (a)]

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 there is a written plan of care for each resident with responsive behaviours that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 24 (1) in that a person who had reasonable grounds to suspect that abuse of a resident had occurred or may occur, did not immediately report the suspicion and the information upon which it is based to the Director.

On a specified date, an alleged incident of staff to resident abuse was reported to the Administrator involving Resident #1. The same day the Administrator started an investigation into the incident. After an interview with Resident #1, staff member #S100 was suspended pending the investigation.

Two days later the home called the police to report the incident of alleged staff to resident abuse.

Six days after the allegation was made, a Critical Incident Report was submitted to the Ministry of Health and Long-Term Care by the home outlining the alleged incident of staff to resident abuse and the outcome of their investigation.

On January 22, 2015, during an interview with the Administrator, she indicated that she could not recall informing the Ministry of Health and Long-Term Care about the alleged abuse prior to submitting the Critical Incident Report and there is no record of any information being reported prior to this date.

Therefore, the home did not immediately report their suspicion of staff to resident abuse and the information upon which it was based to the Director. [s. 24. (1)]

Issued on this 27th day of January, 2015

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

Original report signed by the inspector.