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
Mar 31, 2015	2015_270531_0004	O-001828-15	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

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

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

SUSAN DONNAN (531)

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): February 12 and 13, 2015.

During the course of the inspection, the inspector(s) spoke with Residents, four Personal Support Workers, a Registered Practical Nurse, the Assistant Director of Care, the Director of Care and the Administrator.
During the Course of the inspection the inspector observed resident care, resident health care records and internal investigation file.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 with responsive behaviours.

On a specified date a Critical Incident was submitted to the Ministry of Health and Long Term Care.
The Critical Incident report described the following:
On an identified date a PSW found Resident #1 and Resident #2 on the floor in front of Resident #2's open clothes closet.
It was suspected that Resident # 1 was rummaging in Resident #2's closet, Resident #2 got up to stop Resident #1 and a physical exchange occurred.

Resident #1 was admitted to the home with diagnoses including dementia and depressive episodes.

Upon review of Resident #1's health care record including progress notes and MDS assessments for the past nine months it was noted that Resident #1 has a history of behavioural symptoms. Written strategies for managing Resident #1's behavioural symptoms were not included on the care plan.

On February 12, 2015 during an interview with PSW S #101 and S #102 they noted that the resident does show behavioural symptoms . They confirmed that there were no interventions in place for Resident #1 on the day shift.

On February 13, 2015 PSW S #103 who works nights, noted that Resident #1 has shown behavioural symptoms and acknowledges that he/she is not aware of interventions other than to monitor the resident on nights.

On the same date RPN S #100 confirmed that Resident #1 has shown behavioural symptoms since admission and acknowledged that these symptoms have worsened over the past six months.

Later that day during interviews with the Administrator, the Director of Care and the ADOC as well as a review of Resident #1's care plan, they confirmed that although the resident has a history of behavioural symptoms, written approaches and strategies related to these behaviours were not included in Resident # 1's plan of care.

The Director of Care confirmed that all resident care plans are currently being audited for quality improvement. [s. 6. (1) (a)]

Issued on this 17th day of April, 2015

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

Original report signed by the inspector.