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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Sep 14, 2016	2016_178624_0026	013429-16	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

BAIYE OROCK (624), CATHI KERR (641), KARYN WOOD (601)

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): September 6 – 9 and 12, 2016

The following logs were inspected concurrently:
Log # 016098-16 (Concern regarding medication administration),
Log # 025707-16 (Anonymous complaint on staffing level),
Log # 026485-16 (A missing resident) and
Log # 027572-16 (Alleged staff to resident neglect).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Directors of Care, the Environmental Service Manager, the Dietary Manager, the RAI Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSWs), Housekeeping staff and Maintenance personnel, Family members, residents and the President of Residents Council.
A tour of the building was completed and the following observations were made during the course of the inspection: medication administration, infection prevention and control practises, and staff-resident interaction during the provision of care. Documentation review was also completed for relevant policies and procedures, the staffing plan and staff schedules, resident council minutes, and the licensee internal investigations of incidents related to medication administration, alleged resident abuse and a missing resident.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care for resident #022 was provided related to thirty minute safety checks as specified in the plan.

Related to log #026485-16,

Resident #022 was admitted to the Home on a specified date with a specified diagnosis. The resident was able to foot propel independently in her wheelchair. On a specified date, the resident was trapped on a broken service elevator for a little over two hours. Record review of the plan of care at the time of the incident identified that resident #022 required every thirty minute safety checks in addition to having a safety device applied to prevent the resident from exiting the building without assistance.

A review of the Home's internal investigation identified that on the date the resident was trapped in the elevator, a family member had reported that the service elevator was not working. Ten minutes before the family member reported the malfunctioning elevator, resident # 022 was last checked by PSW #125 and noted to be independently transferring from bed. The Home's investigation identified that one hour after the resident was last seen, PSW #130 reported to RPN #122 that resident #022 had not arrived for a programmed activity. Ten minutes later, RPN #122 spoke to staff about resident #022 and no one had seen the resident for the last one hour. Close to two hours after resident #022 was last seen, RPN #122 went to administer a medication and was not able to locate the resident. Upon realizing that resident #022 was not found, a building search was commenced of all units and the outside grounds, ADOC #112 called into the broken service elevator and no response was heard at this time. Moments later, ADOC #112 called into the broken service elevator again and the resident's response was heard at this time. The fire department was immediately notified and arrived at approximately two and a half hours after the resident was last seen. The fire department was able to open the elevator doors and safely remove resident #022 from the elevator.

During an interview, RPN #122 indicated that she did not suspect the resident was missing until approximately two and a quarter hours after the resident was last seen. RPN #122 indicated that resident #022's plan of care required every thirty minute safety checks and acknowledged that staff do not always have time to complete the thirty minute safety checks, as required.

During an interview, ADOC #112 indicated that resident #022 was known to take the service elevator independently and required every thirty minute safety checks related to the resident's risk of exiting the building without assistance. Following the incident, ADOC #112 identified that PSW #125 had not completed the every thirty minute safety checks for resident #022 while the resident was trapped in the service elevator.

Therefore, on the specified date of the incident, resident #022 was missing for approximately two hours and fifteen minutes and was located on the broken service elevator. Resident #022 did not receive every thirty minute safety checks for more than two hours trapped in the elevator, as specified in the plan of care.

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 the care set out in the plan of care is provided to the resident as specified in the plan specifically related to every thirty minutes checks for resident # 022, to be implemented voluntarily.

WN #2: 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Related to log # 016098-16,

According to records from the Home, on a specified date, a family member of resident #023 reported to RPN #136 that four days ago, RN #131 had given her some medication to administer to the resident with no accompanying instructions on how to administer the medications.

A review of the Home's internal investigation revealed a written statement from RN # 131 acknowledging giving medications to a family member to administer to resident #023. RN # 131 stated in her statement that when residents go on a leave of absence (which was not the case during this incident), family members are usually given the resident's medication to administer to the resident and as such, she had felt it was safe for the family member to administer the medication.

A review of the Licensee's medication administration policy #: RCSM-F-05 of August 15, 2006 and lastly reviewed on April 27, 2016 stated: "Medications will be administered by registered nurses and/or registered practical nurses holding a record of completion of a required medication administration course."

In interviews with RPN #107, ADOC # 103 and DOC # 120, all acknowledged that as per the Licensee's medication administration policy, only registered staff are allowed to administer medication to residents in the home.

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 no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

The Licensee failed to ensure that the use of a PASD was approved by a regulated health professional before the PASD was applied to resident # 014.

Resident # 014 was admitted into the home on a specified date with a specified diagnosis. On a specified date in 2016, resident #014 was observed to be using a personal assistance service device (PASD). The resident was incapable of taking off the PASD. Resident #014's current plan of care indicated that the PASD should be applied in a given situation. In an interview with the resident while using the PASD, the resident stated that the PASD was mainly for comfort. The resident confirmed not being able to take off the PASD. The resident also stated the PASD can be taken off or adjusted as needed.

In an interview with RPN # 109 and PSW #110 both reported that because the resident is incapable of undoing the PASD, it could be considered a restraint. However, both stated that the resident was capable of making decisions about care and had requested the PASD for safety and comfort. As such, it will be considered a PASD rather than a restraint. A review of the resident's health records indicated that the use of the PASD had not been approved by a regulated healthcare professional.

In an interview with the Administrator, she stated that the PASD was used to assist the resident with ADLs, prevent falls, ensure resident's safety and as such, will be considered a PASD. She however acknowledged that there was no order for the PASD and there should have been one before the application of the PASD.

Issued on this 14th day of September, 2016

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

Original report signed by the inspector.