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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 17, 2018	2018_664602_0001	000067-18	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

WENDY BROWN (602), CATHI KERR (641), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 8 - 12 and 15 & 16, 2018

Critical incident log# 021740-17 was also inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, Registered Nurses, Maintenance Manager, Personal Support Workers, Housekeepers, Dietary Manager, RAI Co-ordinator, a private care giver, the Activities Manager, family members and residents.

In addition, electronic heath records, administrative records, licensee policies & programs and meeting minutes were reviewed. The inspector(s) also observed staff and resident care interactions and resident care and services.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Review of the Licensee's "Abuse Policy" ADM-VI-06 dated June 21, 2017:

Policy: Under no circumstances will abuse and/or neglect of residents be tolerated by anyone. Every incident / suspicion of abuse must be reported, investigated, documented and resolved no matter how insignificant or minor the incident may seem.

Definition of Physical abuse: The use of physical force by a person against a person that is contrary to the person's health, safety or well-being. This may include, but is not limited to slapping, pushing, and misuse of a restraint.

Detection and Protection - Staff to Resident:
-Staff, visitors and/or residents, acknowledge that abuse may be happening either by witnessing the incident or by communication of the incident by the person being abuse or by (an) other person(s).
-If there is reasonable grounds to suspect abuse has occurred the Assistant Director of Care (ADOC) or the RN charge Nurse (after business hours) is to be contacted immediately.
-the unit nurse will assess the victim for injury (head to toe assessment) and mental condition, provide first aid and/or send to hospital if necessary.
-if the assailant is on duty, he/she must be sent home on investigatory leave.

A critical incident report was submitted to the Director on a specified date indicating that a PSW hurt a resident while assisting them. The same resident was injured a second time by the same PSW staff. The resident did not report either incident. Subsequently, during care by another PSW, an injury was noted; this was reported to the nurse on duty who confirmed the presence of a new injury. Notifications/reporting as per policy were completed and an investigation was begun.

The ADOC advised that the PSW agreed that the resident had complained of pain when s/he was provided assistance on two separate occasions and acknowledged that s/he did not notify the nurse of either incident.

The investigation concluded that physical abuse had occurred in that PSW staff had used enough force to cause a resident physical injury and/or pain. The home's abuse policy specifically states that every incident/suspicion of abuse must be reported no matter how

insignificant or minor the incident may seem; despite this policy direction, a PSW staff failed to report the excessive use of force causing pain and injury to the same resident on two separate occasions. [s. 20. (1)]

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 staff comply with the home's Abuse policy, specifically reporting of abuse, 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #047 's medication order was changed on a specified date. The orders were transcribed into the resident's Medication Administration Record (MAR), however, the change was not documented in the MAR resulting in the resident receiving two doses of the incorrect medication. The DOC acknowledged that the resident had received the incorrect medications on two occasions as a result of transcription error. The DOC specified that the error was noted 2 days after the medication was changed.

A review of the medication incident report indicated that the resident's physician, the

pharmacy and the resident's power of attorney had been notified of the incident. The resident had been assessed as having no ill effect.

The licensee had failed to ensure that no drug was administered to a resident unless it had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure medications were given to residents #040 and #048 in accordance with directions for use specified by the prescriber.

Resident #040 had a physician's order to receive a specified medication at a specified time and another specified medication at another specified time. On a specified date resident #040 received the wrong dose of the specified medication.

During an interview the DOC acknowledged that resident #040 had received the wrong dose of the medication. A review of the medication incident report indicated that the resident's physician, the pharmacy and the resident's power of attorney had been notified of the incident. The resident had been assessed as having no ill effect.

Resident #048 had an order to receive a specified injectable medication. The resident received a specified number of doses of the specified medication before it was noted that injectable had been primed with a different dosage of the specified medication. The DOC acknowledged that resident #048 received the wrong dose of medication due to the injectable being primed with a different concentration medication. The DOC indicated that she had spoken with the home's pharmacist consultant who indicated that only the first doses would have had a different titration than what was prescribed.

A review of the medication incident report indicated that the resident's physician, the pharmacy and the resident's power of attorney had been notified of the incident. The resident had been assessed as having no ill effect.

The licensee failed to ensure that drugs were administered to residents #040 and #048 in accordance with directions for use as specified by the prescriber. [s. 131. (2)]

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 by ensuring registered nursing staff provide medications as prescribed and in accordance with directions for use a specified by the prescriber, to be implemented voluntarily.

Issued on this 18th day of January, 2018

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

Original report signed by the inspector.