Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
August 10, 11, 2010	2010_143_2901_10Aug1 35019	Other (Critical Incident) Log # O-000305

Licensee/Titulaire
Belcrest Nursing Homes Limited
250 Bridge Street West
Belleville K8P 5N3

Long-Term Care Home/Foyer de soins de longue durée
Belmont Long Term Care Facility
250 Bridge Street West
Belleville K8P 5N3

Name of Inspector(s)/Nom de l'inspecteur(s)
Paul Miller (ID#143)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical incident) inspection involving the transferring of a resident and admission to hospital.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Nursing, a Registered Practical Nurse, a physiotherapist and a Restorative Care Aid.

During the course of the inspection, the inspector: Interviewed staff, reviewed and obtained copies of a resident's health care record and reviewed the home policies and procedures related to Critical Incidents.

The following Inspection Protocols were used during this inspection:
Personal Support Services Inspection Protocol, Pain Inspection Protocol and Critical Incident Response Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O 2007, c.8, s.6 (9)

The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

Findings:

1. A resident sustained a fractured femur.
2. A review of the resident record indicated that no documented assessment of the resident had been completed for 16 hours and 55 minutes.

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 assessments are documented within a timely period. This plan is to be implemented voluntarily.

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WN #2: The Licensee has failed to comply with O. Reg. 79/10 s.107

(4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

2. A description of the individuals involved in the incident, including,

i. names of any residents involved in the incident,

Findings:

1. A critical incident report completed and submitted to the Ministry of Health and Long Term Care on July 15, 2010 did not identify the resident involved in the incident.

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WN #3: 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 uses safe transferring and positioning devices or techniques when assisting residents.

Findings:

1. A Registered Practical Nurse reported to the inspector that a resident stated that a PSW (personal support worker) was transporting the resident too fast.
2. The resident abruptly put a foot down during the transfer.
3. The resident was transferred to hospital and treated for a fracture.

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 residents in wheelchairs are transferred safely. This plan is to be implemented voluntarily.	
Inspector ID #:	143

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** P Miller
Title: **Date:**	**Date of Report (if different from date(s) of inspection).** March 8/11