Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 18, 2020	2020_779641_0015	002814-20, 003461-20, 003898-20, 004418-20, 008585-20, 008641-20, 010130-20, 010924-20, 011330-20	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

CATHI KERR (641), 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): June 11, 2020 onsite and June 15, 16, 17 and 18, 2020 offsite.

This inspection was conducted in reference to the following intakes: Intake log #002814-20, CIS # 2901-000006-20, Log #003461-20, CIS #2901-000009-20 and 2901-000010-20, Log #004418-20, CIS #2901-000014-20, Log #008641-20, CIS #2901-000019-20, Log #011330-20, CIS #2901-000023-20, related to alleged resident to resident abuse; Log #003898-20, CIS #2901-000012-20 related to alleged staff to resident abuse; Log #010924-20, CIS #2901-000022-20, Log #008585-20, CIS #2901-000018-20 related to residents falling resulting in injury; and log #010130-20, CIS #2901-000021-20 related to resident injury due to not following the plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Behavioural Support RPN, Behavioural Support PSW, Physiotherapist, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.
During the course of the inspection, the Inspectors observed staff to resident and resident to resident interactions, reviewed resident health care records and Critical Incident System reports (CIS) and relevant licensee investigation notes, and reviewed policies and procedures related to falls prevention and zero tolerance for abuse.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
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	Légende 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 :

1. The licensee has failed to ensure that the care set out in resident #011's plan of care was provided as specified in the plan for hourly checks.

Review of resident #011's plan of care indicated that the resident's fall prevention interventions included two half rails and that the resident was to be checked on every hour.

During separate interviews with PSW #118, #119 and RPN #117 with inspector #531 on June 16, 2020 they told the inspector, that resident #011's plan of care included hourly checks for resident safety. The PSWs indicated that they checked on resident #011 at the beginning of their shift at approximately 2200 hours, and then at 2330 hours when they found resident #011 with the head of the bed elevated. The resident had slid down in their bed, scrapped their face on the side rail, from which the resident had sustained superficial injuries.

During an interview with the DOC, review of the CIS report and internal documentation, the DOC indicated that resident #011 was checked at 2145 hours and breathing check at approximately 2200 hours and 2330 hours. The DOC further indicated that care was not provided to resident #011 as specified in the plan, as the resident was not checked between 2200 and 2330 hours.

On a specified date on the night shift, the care set out in resident #011's plan of care was not provided as specified in the plan. [s. 6. (7)]

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Issued on this 19th day of June, 2020

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

Original report signed by the inspector.