Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Original Public Report

Report Issue Date: February 2, 2023
Inspection Number: 2023-1385-0002
Inspection Type: Complaint Critical Incident System
Licensee: Belcrest Nursing Homes Limited
Long Term Care Home and City: Belmont Long Term Care Facility, Belleville
Lead Inspector Wendy Brown (602) **Inspector Digital Signature** Wendy K Brown Digitally signed by Wendy K Brown Date: 2023.03.28 11:58:53 -04'00'
Additional Inspector(s) Stephanie Fitzgerald (741726)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 24 - 26, 27 & 30, 2023

The following intake(s) were inspected:

- Intake #00014200/CIS #2901-000027-22 - regarding alleged visitor to resident sexual abuse.
- Intake #00016905/CIS #2901-000034-22 - regarding structural issue and related temperature decline.
- Intake #00018586 - complaint regarding improper care and obtaining consent for medication changes.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Resident Care and Support Services
Prevention of Abuse and Neglect
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that a standard issued by the Director, with respect to support for residents to perform hand hygiene prior to receiving meals, was complied with. In accordance with additional requirement 10.4 h). under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022), the licensee shall ensure that the hand hygiene program includes support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

Rationale and Summary: A Personal Support Worker (PSW) was observed assisting a resident to a dining area for a meal service. Hand hygiene was not offered to the resident on entry, or once they were seated. A sign was noted outside of the dining room, which indicated, "please be sure resident and staff hands are cleaned with hand sanitizer when entering the dining room prior to meal". Interviews with PSW staff confirmed hand hygiene should be offered prior to entry to the dining room for meals or offered at the table; failure to support hand hygiene at this time increases the risk of virus transmission among residents and staff.

Sources: Dining area observation and interviews with the IPAC lead and PSW staff. [602]

WRITTEN NOTIFICATION: Air temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 24 (1)

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary: While conducting a record review of the Long Term Care Home's temperature of rooms log sheet, there were five dates noted, where air temperatures were below 22 degrees Celsius on a unit in the home. Interviews with the Environmental Service Manager (ESM) and the Administrator confirmed there was a hole in a soffit, which resulted in a draft of cold air entering the facility, and a resulting decline in temperature. There was an increased risk to resident comfort and safety when the licensee failed to ensure the home was maintained at a minimum temperature of 22 degrees Celsius.

Sources: Temperature log sheets for December 2022 and January 2023 and interviews with the Administrator and the ESM. [741726]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 2.

The licensee failed to ensure that the Director was informed of an environmental hazard that effected the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours in the home, no later than one business day after the occurrence of the incident. Specifically, the licensee failed to report a decrease in temperature, caused by structural damage, occurring over more than six hours.

Rationale and Summary: A Critical Incident System (CIS) report indicated that a structural issue caused a draft and reduced temperatures in a section of a unit in the home. A service provider contracted to check the heat source on this unit, discovered a hole in the gable end of a hall, exposing the exterior. Materials such as cardboard, blankets and duct tape, were used to temporarily seal the hole.

A review of room temperature log sheets documented temperatures of less than 22 degrees Celsius over a nine hour period; this was not reported to the Director for several days. Interviews with the ESM and the Administrator confirmed the temperature decline was reported to the Director several days later. Failure to immediately report incidents that may affect the provision of care or the safety, security or well-being of one or more residents, puts residents at risk of additional harm.

Sources: CIS report, temperature log sheets for December 2022 and January 2023, and interviews with the Administrator and the ESM. [741726]