

Ministry of Long-Term Care

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

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: January 12, 2024	
Inspection Number: 2023-1385-0006	
Inspection Type: Complaint Critical Incident	
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
Additional Inspector(s) Ashley Bernard-Demers (740787)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 6, 8, 11, 12, 18-21, 2023.

The following intake(s) were inspected:

- Intake: #00094772/CIS #2901-000025-23 - regarding alleged staff to resident neglect.
- Intake: #00094898/CIS #2901-000026-23 - regarding unexplained resident bruising.
- Intake: #00095866/CIS #2901-000028-23 - regarding alleged staff to resident emotional abuse.
- Intake: #00097892/CIS #2901-000032-23 - regarding a fall with injury and transfer to hospital.
- Intake: #00099287/CIS #2901-000034-23 - regarding alleged resident to resident sexual abuse.

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- Intake: #00099492/CIS #2901-000038-23 - regarding a fall with injury and transfer to hospital.
- Intake: #00102870/CIS #2901-000042-23 - regarding an unexpected death of a resident.
- Intake: #00101864 - Complaint regarding alleged staff to resident neglect resulting in fall with injury and transfer to hospital.

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

- Resident Care and Support Services
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure that clear direction was provided for a resident's clip alarm while in bed. A progress note indicated that a resident's clip alarm had been discontinued; however, several weeks later, a subsequent note indicated that a Personal Support Worker (PSW) reported a clip alarm was used for the resident overnight, resulting in a skin tear.

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Sources: A review of the Critical Incident System (CIS) report; resident progress notes and plan of care, and an interview with the RAI/ Restorative Coordinator. [740787]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee failed to ensure that the home's Abuse policy was complied with for a resident, in that an allegation of emotional and physical abuse was not immediately reported by a PSW staff member to the unit nurse.

In a second incident involving two other residents, the unit nurse failed to comply with the Abuse policy in that they did not immediately report suspected resident to resident sexual abuse to the on call manager, resulting in a delay in reporting to the Director.

Sources: A review of CIS reports, the Abuse Policy, and an interview with the Director of Care (DOC). [740787] [602]

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the

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review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure the home's Falls Prevention and Management Program policy, related to post falls investigation, was complied with for a resident.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that written policies and protocols are developed for falls prevention and management and ensure they are complied with.

Specifically, staff did not comply with the licensee's Falls Prevention and Management Program policy when they did not complete the Post Falls Investigation assessment thoroughly and immediately, after a resident fell.

Sources: A review of the Falls Prevention and Management Program policy, resident assessments; and an interview with the RAI/ Restorative Care Coordinator. [740787]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

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The licensee failed to ensure that staff participated in the implementation of the IPAC program by not complying with the home's masking expectations when in resident care areas.

Sources: Observations of a PSW, the Environmental Services Manager and a maintenance/ housekeeping staff, and an interview with the DOC. [740787]