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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 26, 2015	2015_340566_0004	T-1639-15	Resident Quality Inspection

Licensee/Titulaire de permis

TORONTO AGED MEN'S AND WOMEN'S HOMES
55 Belmont Street TORONTO ON M5R 1R1

Long-Term Care Home/Foyer de soins de longue durée

BELMONT HOUSE
55 BELMONT STREET TORONTO ON M5R 1R1

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

ARIEL JONES (566), JUDITH HART (513), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 11, 12, 13, 16, 17, 18, 19, 20, 23, and 24, 2015.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the assistant director of care (ADOC), director of support services, maintenance supervisor, registered dietitian, dietary supervisor, skin care coordinator, registered staff members, personal support workers (PSW), dietary aides, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Observations and staff interviews on March 18, 2015, confirmed that the activity room on an identified floor was unsupervised, open and accessible to residents during the day. The activity room contains a stove which is kept locked by the use of a breaker switch, located directly above the stove. Observations revealed that the breaker could be reached by anyone standing in front of the stove. Interview with the home's director of support services confirmed that the breaker could possibly be reached by a resident who is not in a wheelchair, and should be either locked or moved to a place out of sight and out of reach of residents. The director of support services confirmed that the breaker will be locked until it can be moved.

Observations confirmed that by an identified time later on March 18, 2015, a lock was present on the breaker, preventing it from being set to "on", thereby preventing the stove from being used. [s. 5.]

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 that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other.

A record review for resident #006 revealed that the resident had experienced weight loss of greater than 10% over the past six months. The resident's current dietary order and care plan outlined that the resident was to receive an identified supplement at a specific meal to promote weight gain.

Interviews with members of the registered nursing staff revealed that the resident often refuses the identified supplement and therefore the dietary staff had stopped providing it. An identified PSW confirmed that on March 18, 2015, the identified supplement was not provided to resident #006 during the specified meal service, and that he/she was unsure if the resident was still receiving it.

An interview with the registered dietitian revealed that the order for the identified supplement had never been discontinued, that dietary staff should have been providing the supplement as per the care plan, and that the resident continued to require the supplement related to his/her high nutritional risk.

An interview with the DOC confirmed that if the dietary staff stopped providing the supplement without the knowledge or recommendation of the dietitian, then staff did not collaborate in the development or implementation of the resident's plan of care. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Observations, staff interviews and record review confirmed that the plan of care for resident #007 states that as per the resident's request, bed rails are not being used. Staff interviews confirmed that the resident does not like for the side rails to be used, and becomes agitated if he/she sees the rail up.
Inspectors observed the resident's left hand side rail to be in the up position on five different occasions during the inspection period. The resident was not in bed at the time of the observations. [s. 6. (7)]

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 that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other, and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways are:
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be canceled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Observations on March 17, 2014, indicated that doors to main floor stairwells are not kept locked and are not equipped with a door access control system or an audible door alarm. The inspector observed eight identified doors which lead to stairwells on the main floor to be unlocked. All of these doors could be accessed by residents of the long term care home.

The home's director of support services confirmed that the doors to stairwells on the main floor are not kept locked and are not connected to a door access control system or an alarm. The director of support services confirmed that doors leading to the outside of the home, and doors leading to stairwells on every floor but the main floor are locked with a maglock system which will sound an alarm when the doors are opened. [s. 9. (1)]

2. Observations on March 17, 2015, confirmed that a door leading to the outside of the home was not kept locked. At an identified time on March 17, the inspector observed the door beside the loading dock on the east side of the building to be unlocked. No staff was within sight at the time. This door is accessible to residents and leads to a non-secured area outside of the home.

At a specified time, later on the same day, the inspector, accompanied by the director of support services and the maintenance supervisor, observed the door beside the loading dock to be unlocked. Home staff were present in the area, but were not using the door at the time. No alarm was audible on either occasion. The director of support services was able to secure the door by pulling it shut.
The director of support services stated that the door should have locked when closed, and that they would be monitoring to ensure that the maglock on the door functioned properly. The maintenance supervisor confirmed that the alarm system for the door was shut off during the day as it is used frequently for daytime deliveries to the home. [s. 9. (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 that all doors leading to stairways are:
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Staff interviews and record review confirmed that resident #007 currently has skin tears on identified areas of both the upper and lower extremities. These skin tears are currently being treated, but have not been assessed by registered nursing staff using a clinically appropriate assessment instrument that is designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. Staff interviews and record review confirmed that resident #009 sustained a skin tear to an identified area of an upper extremity on an identified date in February 2015. Staff interviews and record review confirmed that although the skin tear was treated using the home's protocol for skin tears, a skin assessment was not performed by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

3. Record review, staff and resident interviews confirmed that resident #008 sustained a skin tear to an identified area of a lower extremity on an identified date in February 2015. Staff interview and record review confirmed that the skin tear was immediately treated, but was not assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

An interview with the home's skin care coordinator confirmed that the home does not use a skin assessment instrument to assess skin tears or wounds, other than pressure, vascular or arterial ulcers. [s. 50. (2) (b) (i)]

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 that the resident exhibiting altered skin integrity, including skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

Issued on this 14th day of April, 2015

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

Original report signed by the inspector.