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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Dec 29, 2016	2016_252513_0013	033641-16	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

JUDITH HART (513), SARAN DANIEL-DODD (116)

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): December 5, 7, 8, 9, 12, 13, 14, 15, 16, 20, 21, 2016.

The following complaint inspection was conducted concurrently with the RQI: 031022-16 regarding plan of care, dietary services, nutrition care, continence care, and pain management.

The following critical incident inspection was conducted concurrently with the RQI: 014555-16 regarding duty to protect.

During the course of the inspection, the inspector(s) spoke with residents and families, director of care (DOC), associate DOC (ADOC), registered nursing staff, personal support workers (PSWs), registered dietitian (RD), dietary aide, director of support services (DSS), housekeeping supervisor, housekeeper, receptionist, unit clerks, substitute decision makers (SDMs), Residents' Council president and Family Council president.

During the course of the inspection, the inspector(s): conducted a tour of the home; observed medication administration, resident to resident interactions, staff to resident interactions and the provision of care; reviewed resident health care records, staff training records, meeting minutes for Residents' Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
2 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 was a safe and secure environment for its residents.

The following were observed during the initial walk-through of the home on a designated date:
- The door to the kitchenette located on a specific area was unlocked, unsupervised and accessible from the hallway corridor.
- The coffee percolator and serving table were turned on.
- Resident #017 was observed wandering up and down the hallway and in close proximity to the kitchenette.

The dietary aide, staff #125, was observed to return to the kitchenette approximately five minutes later. During an interview with staff #125 he/she stated that it was fine to keep the door unlocked as no one was going to wander into the kitchenette. Further interviews held with RN #126 and the DOC indicated that the door to the kitchenette is to be locked at all times when unsupervised.

Another observation made during the initial tour found the door accessing the outdoor patio(s) located on two specified units were unlocked and unsupervised. Inspector #116 was able to open the door and gain access to the patio. An interview with the DOC indicated that the patio doors should be locked at all times when unsupervised.

The findings of the unlocked and unsupervised areas described above indicate the home failed to ensure that the home is a safe and secure environment for its residents. [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. (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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

During the RQI, resident #003 was observed to have a small dressing on a specified body area.

A review of the written plan of care, physician orders, progress notes and treatment record did not reveal any directions were provided regarding the dressing to the specified body area.

Interviews with PSW #118 and RN #116 could not confirm knowledge of, nor purpose of, the dressing on resident #003’s specified body area. Further inquiry by RN #116 revealed the dressing was a result of a medical procedure.

An interview with RN #116, RN #114 and the DOC confirmed that clear directions were not provided to staff and others who provide direct care to the resident regarding the purpose and location of the dressing. [s. 6. (1) (c)]

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 plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident’s right to have his or her personal health information kept confidential was fully respected and promoted.

On December 5, 2016, during the initial walk-through of the home, inspector #116 observed the door to a specific room to be locked, however, the door was not latched. Inspector #116 was able to gain access to this room, which contained multiple health records. There were no staff in attendance and this area was easily accessible to individuals on the unit. Interviews held with the unit clerk #127, RN #128 and the DOC indicated that the health records were left unattended, and the specified room should be locked and inaccessible when not in use, indicating the home had not fully respected the resident’s right to have his or her personal health information kept confidential. [s. 3. (1) 11. iv.]

Issued on this 12th day of January, 2017

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

Original report signed by the inspector.