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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2018	2017_659189_0026	028124-17	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

NICOLE RANGER (189), CECILIA FULTON (618)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 11, 12, 13, 14, 15, 19, 2017.

The following critical incident reports were inspected concurrently with the Resident Quality Inspection (RQI):
Related to fall prevention:
log #033645-16
log #024430-17

Related to safe and secure home:
log #028789-17

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Nursing Supervisor, Registered Dietitian (RD), Family Council President, Residents' Council President, registered nurse(RN), registered practical nurse (RPN), personal support workers (PSW), residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **1 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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the residents is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there was none, in accordance with prevailing practices to minimize risk to the resident.

This inspection was initiated due to a resident observation which triggered potential side rail restraint for resident #001.

During stage one, resident #001 was observed to have bilateral side rails engaged and his/her written plan of care revealed that side rails were indicated both side rails up, per resident request.

Interview with Director of Care (DOC) revealed that no assessment of the resident as it pertains to the use of bed rails had been conducted and that at the time of this inspection, no residents using bed rails had been assessed. According to the DOC, the majority of residents living in the home use some form of bed rails. [s. 15. (1) (a)]

2. This inspection was initiated due to a stage one resident observation which triggered potential side rail restraint for resident #002 and #003.

During stage one, resident #002 was observed to have the left side ¼ rails engaged and his/her written plan of care revealed that side rails were indicated left side rails up, per resident request.

Record review of resident #002's medical orders did not reveal orders for the use of the side rails. There is also no documentation available to establish what safety risk were identified, if any with bed rails applied.

During stage one, resident #003 was observed to have the left side ¼ rails engaged and his/her written plan of care revealed that side rail were indicated left side rails up, per resident request.

Record review of resident #003 medical orders did not reveal orders for the use of the side rails. There is also no documentation available to establish what safety risk were identified, if any with bed rails applied.

Interview with the Director of Care (DOC) revealed that no assessment of the residents as it pertains to their use of bed rails or risk associated with having them applied had been conducted at the time of the application of the bed rail to the resident’s bed. At the time of this inspection, no residents using bed rails in the home had been assessed. According to the DOC, 47 out of 140 residents in the home uses bed rails and did not have an assessment completed before the application of the bed rail.

The severity of the non-compliance was determined to be a level 2 potential for actual harm. The scope of the issue was level 3 widespread as resident #001, #002 and #003 were not assessed for use of the bed rails. The home had a level 2 compliance history with one or more non-related non-compliances in the last 36 months.

The home applies the side rail on the residents' bed when requested by the resident or family member, without conducting an assessment or assessing the bed system evaluated to minimize the risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

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 there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident.

On two identified date, the home submitted a Critical Incident System Reports (CIS) pertaining to falls for resident #004.

Record review revealed that Morse Fall Assessment, had determined that resident was at high risk for falls.

Record review revealed that bed side floor mat had been requisitioned for the resident on an identified date.

Review of the written plan of care did not include floor mat as one of the fall preventions strategies for resident #004. Interventions identified in the written plan of care included use of safety equipment, routine toileting, hourly safety checks and to ensure environment is free of clutter.

Interview with registered staff #104, revealed that floor mat were part of this residents care plan and were supposed to be positioned when the resident was in bed. Staff #104 revealed that the floor mat were not in place when the resident fell on an identified date.

Interview with PSW #105 revealed that this was the first time he/she had been assigned to care for resident #004. PSW #105 revealed that he/she would rely on the written plan and information conveyed during the shift report to determine what care the resident required. PSW #105 revealed that the floor mat was not in position at the resident's bedside on this shift.

Review of the progress notes and the post-fall huddle reveal that the floor mats were not in place at the resident's bedside when he/she fell.

Review of the written plan of care was conducted with the DOC, and the DOC confirmed that the intervention of the floor mat was not in resident #004's plan of care. [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 there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident, 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:
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).

Findings/Faits saillants :

1. The Licensee has failed to ensure that all doors leading to non-residential areas were 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.

During the initial tour of the home, the inspector observed two identified floor balconies doors to be unlocked and unsupervised and both doors were able to be opened permitting access to the enclosed balconies.

Interview with resident #013, whose room is directly across the hall from an identified floor balcony, informed the inspector that he/she had complained about that door not being locked and people opening it as it caused a draft.

Interview with the DOC suggested that people may have been doing work on the balconies and that is why the doors were unlocked. The inspector did not observe any people working on or around the balcony.

The DOC confirmed that these doors should have been locked. [s. 9. (1) 2.]

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 following rules are complied with: 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place was complied with.

A review of the home policy "Medication – Storage of Surplus Discontinued and Drug Destruction ", revised January 2015, directs the staff for discontinued or expired medication, the registered staff will remove the medication from the medication cart, and stored in a storage area in the nursing station and that it is separate from drugs that are available for administration to a resident.

During an observation of the medication administration pass with RPN #106, the inspector observed an expired medication in the medication cart. Interview with RPN #106 revealed that the discontinued medication should not be stored in the medication cart with the current available drugs for the residents.

Interview with the DOC confirmed that discontinued medications are to be stored in a storage area in the nursing medication room, and that it is to be separate from drugs that are available for administration to a resident. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

During observations of the medication cart with RPN #106, the inspector noted various non drug and non drug-related items being stored in the medication carts and the double locked narcotics bins. These items included money, E-pen ink and doctors prescription pads. Interview with the DOC confirmed these items should not be stored in the narcotic box. [s. 129. (1) (a)]

Issued on this 15th day of January, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NICOLE RANGER (189), CECILIA FULTON (618)
Inspection No. / No de l'inspection :	2017_659189_0026
Log No. / No de registre :	028124-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 11, 2018
Licensee / Titulaire de permis :	TORONTO AGED MEN'S AND WOMEN'S HOMES 55 Belmont Street, TORONTO, ON, M5R-1R1
LTC Home / Foyer de SLD :	BELMONT HOUSE 55 BELMONT STREET, TORONTO, ON, M5R-1R1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARIA ELIAS

To TORONTO AGED MEN'S AND WOMEN'S HOMES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

Ensure resident #001, #002, #003 and all residents utilizing bed rails are assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, and document the results and recommendations.

Accurately document the results of any future bed assessments and continuously maintain the document when changes to the bed system occurs.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, that residents were assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there was none, in accordance with prevailing practices to minimize risk to the resident.

This inspection was initiated due to a stage one resident observation which triggered potential side rail restraint for resident #002 and #003.

During stage one, resident #002 was observed to have the left side ¼ rails engaged and his/her written plan of care revealed that side rails were indicated

left side rails up, per resident request.

Record review of resident #002's medical orders did not reveal orders for the use of the side rails. There is also no documentation available to establish what safety risk were identified, if any with bed rails applied.

During stage one, resident #003 was observed to have the left side ¼ rails engaged and his/her written plan of care revealed that side rail were indicated left side rails up, per resident request.

Record review of resident #003 medical orders did not reveal orders for the use of the side rails. There is also no documentation available to establish what safety risk were identified, if any with bed rails applied.

Interview with the Director of Care (DOC) revealed that no assessment of the residents as it pertains to their use of bed rails or risk associated with having them applied had been conducted at the time of the application of the bed rail to the resident's bed. At the time of this inspection, no residents using bed rails in the home had been assessed. According to the DOC, 47 out of 140 residents in the home uses bed rails and did not have an assessment completed before the application of the bed rail.

The severity of the non-compliance was determined to be a level 2 potential for actual harm. The scope of the issue was level 3 widespread as resident #001, #002 and #003 were not assessed for use of the bed rails. The home had a level 2 compliance history with one or more non-related non-compliances in the last 36 months.

The home applies the side rail on the residents' bed when requested by the resident or family member, without conducting an assessment or assessing the bed system evaluated to minimize the risk to the resident. (189)

2. This inspection was initiated due to a resident observation which triggered potential side rail restraint for resident #001.

During stage one, resident #001 was observed to have bilateral side rails engaged and his/her written plan of care revealed that side rails were indicated both side rails up, per resident request.

Interview with Director of Care (DOC) revealed that no assessment of the resident as it pertains to the use of bed rails had been conducted and that at the time of this inspection, no residents using bed rails had been assessed. According to the DOC, the majority of residents living in the home use some form of bed rails.
(618)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector /
Nom de l'inspecteur : NICOLE RANGER

Service Area Office /
Bureau régional de services : Toronto Service Area Office