Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2020	2019_810654_0010	014676-19	Critical Incident System

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

SIMAR KAUR (654)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 18, 19 and 20, 2019.

The following intake was completed during this Critical Incident System (CIS) Inspection:

Log #014676-19, CIS #506-000004-19 related to a fall incident resulting in an injury.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC); Registered Staff RN/ RPN; Personal Support Worker (PSW); and Private Care Provider (PCP).

During the course of the inspection, the inspector made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted record reviews and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

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 :

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A CIS was submitted to the Ministry of Long-Term Care (MLTC) related to a fall incident of resident #001 resulting in an identified injury.

Review of the resident’s plan of care indicated that they were at risk for falls due to an identified cognitive impairment. Interventions indicated that the resident to have two identified falls prevention and management equipment.

During the resident observation on an identified date, with PSW #104 and the resident’s Private Care Provider (PCP) #103 present, indicated that the resident did not have the two above identified falls prevention and management equipment in place.

Interview with PCP #103 indicated that they had worked with the resident daily since an identified month in 2019. The resident did not have the first above identified equipment from approximately the last five months.

Interview with PSW #104 indicated that they had provided care to the resident on the above identified date, and they did not apply the first identified falls prevention and management equipment. Regarding the second above identified equipment, they indicated that the resident’s identified mobility device was washed by the night staff and they could have forgotten to replace the second equipment in their mobility device.

During an interview with RN #105, they reviewed the resident’s plan of care and indicated that the resident was required to have the two above identified falls prevention and management equipment as per their plan of care.

Interview with ADOC #102 indicated that PSWs were responsible to ensure that resident #001 was provided with the two above identified falls prevention and management equipment. They further acknowledged that the care set out in the plan of care was not provided to resident #001 on the above identified date.

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 care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.

Issued on this 23rd day of January, 2020

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

Original report signed by the inspector.