Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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 13, 2021	2020_751649_0027	017182-20	Complaint

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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 8, 10, 11, 14, 15, 16, 17, off-site on 9, and 13, 2020.

**The following intake was completed during this Complaint Inspection:
Log #017182-20 related to prevention of abuse and neglect and reporting and complaints.**

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurse (RN), Registered Dietitian (RD), Registered Practical Nurses (RPNs), Health Care Aides (HCAs), residents, and family member.

During the course of the inspection the inspector reviewed resident's health records, staffing schedules, conducted observations related to the home's care processes, staff to resident interactions, and reviewed relevant policies and procedures.

**The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Skin and Wound Care**

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

**2 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	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. 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 one resident.

A resident sustained a fall from their mobility device when a feature on the device was not working properly. The resident exhibited responsive behaviours, and required a specific mobility device for safety and comfort. As a result of the feature on the resident's mobility device not working properly, the resident sustained a fall from the device, that resulted in an injury. The home's failure to take immediate action when function on the resident's mobility device was not working properly led to the resident's fall and injuries.

Sources: Review of the resident's health records, progress notes, interviews with DOC, other staff, and resident's Substitute Decision-Maker (SDM). [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. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

The resident’s care plan directed staff to transfer the resident using a mechanical lift, with two staff. According to the resident's care plan they were unable to weight bear. Staff interviews revealed that the resident was transferred by one staff, two staff, and when unable to weight bear the mechanical lift was used. Staff were not following the resident’s care plan during their transfers, thus placing the resident at risk of fall and injury.

Sources: Review of a resident's care plan, progress notes, interviews with DOC, other staff, and resident's SDM. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised, with necessary modifications, with respect to resident’s bedtime.

A resident’s care plan indicated their preferred bedtime. Staff interviews confirmed that they were putting the resident to bed an hour to an hour and a half earlier than the bedtime indicated in their care plan. In January 2020, resident’s SDM requested a change to the resident's bedtime routine. This new requested bedtime was not implemented for the resident, and their care plan was not revised and updated.

Sources: Review of the resident's care plan, progress notes, interviews with DOC, other staff, and SDM. [s. 6. (11) (a)]

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 resident as specified in the plan and a resident is reassessed and the plan of care reviewed, and revised with respect to reassessment and revision, to be implemented voluntarily.

Issued on this 21st day of January, 2021

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

Original report signed by the inspector.