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

Toronto Service Area Office
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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 14, 2022	2021_846665_0007	001955-21	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

JOY IERACI (665), JULIEANN HING (649)

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): October 26, 27, 28, 29, November 1, 2, 3, 4, 5 and 8, 2021.

The following intake was completed in this critical incident system (CIS) inspection:
- Log #001955-21, CIS #2985-000002-21, related to falls.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Physician, Assistant Director of Care (ADOC), Quality and Education Coordinator, Nursing Supervisor (NS), Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Health Care Aides (HCAs).

During the course of the inspection, the inspectors conducted observations of the provision of resident care and services, reviewed clinical records and pertinent policies.

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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	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. (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 of resident #003 collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to resident #003's fall with injury.

Assessment of resident #003 after the fall indicated that they were in pain. Pain medication was given to the resident, but the site of the pain was not identified. A follow-up pain assessment was completed few hours later, and the resident was still in pain, and the pain medication was documented as ineffective. There was no documentation that the physician was informed that the pain medication was ineffective, or collaboration with any other staff to determine the location of the resident's pain post-fall.

A late entry note was made on the third day after the resident's fall by RPN #110 who documented that they had not completed a thorough assessment of resident #003 after their fall.

RPN #110 told the inspector that due to the resident's responsive behaviour, they were unable to perform a thorough post-fall assessment. They stated that they had reported to the incoming nurse to complete an assessment of the resident after their responsive behaviour had subsided. There was no documentation that such an assessment was

completed by the incoming nurse, and they were unavailable for an interview during this inspection.

The next day resident #003 was assessed by RN #123 when they were not ambulating as usual and complained of pain. The resident was transferred to hospital.

RN #123 told the inspector that they became aware of resident #003’s fall from shift report the following morning. They were advised by staff that when the resident was transferred from bed to the wheelchair they were in pain and assessed for a specified injury.

Physician #124 confirmed that they were not informed by the home’s staff when resident #003’s pain medication was documented as ineffective on an identified date.

ADOC #108 became aware of resident #003’s fall from the report the following day and acknowledged that it was documented that the resident had not sustained an injury. They explained that they had spoken with RPN #110 when they became aware of the resident’s fall and they had confirmed that a thorough post-fall assessment was not completed for the resident. They stated that they had spoken with the incoming nurse who had documented that the resident’s pain medication was ineffective, and they had acknowledged that they should have notified the physician. ADOC #108 acknowledged a lack of collaboration in the assessment of resident #003 after they fell.

Sources: Review of resident #003’s clinical records, CIS report #2985-000002-21, and interviews with RPN #110, RN #123, ADOC #108 and other staff. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #003, #008 and #009.

A critical incident report was submitted to the MLTC related to resident #003's fall with injury. Resident #004 had asked resident #003 to transfer them resulting in both residents falling.

A review of resident #004's care plan under falls indicated that they required the use of a chair sensor when up in the wheelchair which had been implemented in the resident's care plan prior to the above mentioned fall.

RPN #110 recalled that the chair alarm had not gone off when resident #004 fell from

their wheelchair.

Observation of resident #004 by Inspector #649 revealed that the resident did not have the chair sensor in use when they were up in their wheelchair. HCAs #121 and #122 both confirmed the inspector's observation.

ADOC #108 acknowledged that resident #004's care plan was not followed with regards to the use of the chair sensor.

Sources: Review of resident #004's clinical records, observations on two identified dates, and interviews with HCAs #121, #122, #129, ADOC #108, and other staff. [s. 6. (7)]

3. As a result of non-compliance identified for resident #004 the sample was expanded to residents #008 and #009.

Resident #008's care plan under falls indicated that they required the use of a chair sensor when up in their wheelchair.

Observation of resident #008 by Inspector #649 revealed that the resident did not have the chair sensor in use. This observation was confirmed by HCA #129.

HCA #130, who worked with resident #008 when the observation was made, advised that they had not realized that resident #008 did not have the chair sensor.

ADOC #108 acknowledged that resident #008's care plan was not followed and that the resident still required the chair sensor.

Sources: Review of resident #008's clinical records, observation on an identified date, and interviews with HCA #130, ADOC #108, and other staff. [s. 6. (7)]

4. Resident #009's care plan under falls indicated that they required the use of a chair sensor when up in the wheelchair.

Observations by Inspector #649 of resident #009 on two consecutive days, revealed that the resident did not have the chair sensor in use. HCA #129 confirmed the first observation by the inspector.

HCA #129 acknowledged that the resident was at risk for falls and stated the resident

would remove the chair sensor. They stated that they had reported this to the nurse but could not recall who.

The second observation of resident #009 was brought to Nursing Supervisor #133's attention who advised that they personally made sure that the chair sensor was on the resident's wheelchair, and created an additional reminder for staff to document its placement each shift.

ADOC #108 acknowledged that resident #009's care plan was not followed.

Sources: Review of resident #009's clinical records, observations on two identified dates, and interviews with HCA #129, ADOC #108, and other staff. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
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 staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident’s written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was created and maintained for resident #003.

A CIS report was submitted to the MLTC related to resident #003’s fall with injury.

The home was unable to provide documentation of a clinical monitoring tool for resident #003 after they fell and sustained injury.

ADOC #108 confirmed that they were unable to locate the monitoring tool for resident #003. They explained that they did not think the monitoring tool was started as there was no documentation of it being completed in the resident’s progress notes.

Sources: Review of resident #003’s clinical records and interview with ADOC #108. [s. 231. (a)]

Issued on this 28th day of January, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) : JOY IERACI (665), JULIEANN HING (649)

Inspection No. / No de l’inspection : 2021_846665_0007

Log No. / No de registre : 001955-21

Type of Inspection / Genre d’inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jan 14, 2022

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:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA.

Specifically, the licensee must:

1. Ensure that the provision of chair sensors set out in the plan of care are provided to residents #004, #008, and #009 as specified in the plan.

2. Implement a process to ensure that staff monitor residents #004, #008, and #009 for the presence of chair sensors on applicable shifts.

3. Conduct random audits of residents #004, #008, and #009 to ensure the use of chair sensors for a minimum of one month, or until no further concerns are identified.

4. The home must maintain a documented record for steps two and three, including the person responsible, date and time, and outcome.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #003, #008 and #009.

A critical incident report was submitted to the MLTC related to resident #003's fall with injury. Resident #004 had asked resident #003 to transfer them resulting in both residents falling.

A review of resident #004's care plan under falls indicated that they required the use of a chair sensor when up in the wheelchair which had been implemented in

the resident's care plan prior to the above mentioned fall.

RPN #110 recalled that the chair alarm had not gone off when resident #004 fell from their wheelchair.

Observation of resident #004 by Inspector #649 revealed that the resident did not have the chair sensor in use when they were up in their wheelchair. HCAs #121 and #122 both confirmed the inspector's observation.

ADOC #108 acknowledged that resident #004's care plan was not followed with regards to the use of the chair sensor.

Sources: Review of resident #004's clinical records, observations on two identified dates, and interviews with HCAs #121, #122, #129, ADOC #108, and other staff.
(649)

2. As a result of non-compliance identified for resident #004 the sample was expanded to residents #008 and #009.

Resident #008's care plan under falls indicated that they required the use of a chair sensor when up in their wheelchair.

Observation of resident #008 by Inspector #649 revealed that the resident did not have the chair sensor in use. This observation was confirmed by HCA #129.

HCA #130, who worked with resident #008 when the observation was made, advised that they had not realized that resident #008 did not have the chair sensor.

ADOC #108 acknowledged that resident #008's care plan was not followed and that the resident still required the chair sensor.

Sources: Review of resident #008's clinical records, observation on an identified date, and interviews with HCA #130, ADOC #108, and other staff.
(649)

3. Resident #009's care plan under falls indicated that they required the use of a chair sensor when up in the wheelchair.

Observations by Inspector #649 of resident #009 on two consecutive days, revealed that the resident did not have the chair sensor in use. HCA #129 confirmed the first observation by the inspector.

HCA #129 acknowledged that the resident was at risk for falls and stated the resident would remove the chair sensor. They stated that they had reported this to the nurse but could not recall who.

The second observation of resident #009 was brought to Nursing Supervisor #133's attention who advised that they personally made sure that the chair sensor was on the resident's wheelchair, and created an additional reminder for staff to document its placement each shift.

ADOC #108 acknowledged that resident #009's care plan was not followed.

Sources: Review of resident #009's clinical records, observations on two identified dates, and interviews with HCA #129, ADOC #108, and other staff.

An order was made by taking the following factors into account:

Severity: There was actual harm to resident #004 and actual risk of harm to residents #008 and #009 when their chair sensors were not provided.

Scope: This non-compliance was widespread as the issue affected all three residents reviewed.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (7) and two voluntary plan of correction (VPCs) were issued to the home. (649)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 08, 2022

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 14th day of January, 2022

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Joy Ieraci

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