Ontario

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
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Original Public Report

Report Issue Date July 14, 2022
Inspection Number 2022_1485_0001
Inspection Type
☐ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ____________________

Licensee
Toronto Aged Men's and Women's Homes

Long-Term Care Home and City
Belmont House
55 Belmont Street, Toronto

Lead Inspector
Ivy Lam (646)

Inspector Digital Signature

Additional Inspector(s)
Inspector #741073 (Ryan Randhawa) was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 28, 29, and 30; and July 5, 6, and 7, 2022.

The following intake(s) were inspected during this follow-up inspection:

- # 001767-22 safe transferring devices and techniques; and
- # 001766-22 related to provision of fall prevention interventions.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 36	2021_846665_0006	001	Ivy Lam (646)
LTCHA, 2007	s. 6. (7)	2021_846665_0007	001	Ivy Lam (646)

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that all residents were assessed at least once a day for signs and symptoms of COVID-19, including temperature checks, as required by a Minister's Directive.

Rationale and Summary

The Minister's Directive specified that all residents were to be assessed at least once a day for signs and symptoms of COVID-19, including temperature checks.

From April 1 to July 4, 2022, the residents residing in following home areas did not receive a daily COVID-19 assessment:
5 West: 9 days in April, 22 days in May, 24 days in June, and 2 days in July;
4 West: 20 days in April, 24 days in May, 24 days in June, and 2 days in July;
2 West: 20 days in May, 23 days in June.

The RN and the DOC indicated it was the registered staff's role to complete the daily assessment and temperature checks, but it was not done.

There was a risk to timely identification of residents with COVID-19 when daily assessments of residents' signs and symptoms of COVID-19 was not done.

Sources: Minister's Directive: COVID-19 response measures for long-term care, COVID-19 Resident Screening Tool from April 1 to July 4, 2022, COVID-19 guidance document for long-term care homes in Ontario - updated June 11, 2022; observations of residents and staff on the units; interviews with the RN, IPAC lead, DOC, and other staff.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that a standard issued by the Director with respect to IPAC was followed, related to point-of-care signage.

Rationale and Summary

The home's policy indicated any resident showing signs or symptoms of COVID-19 should have droplet/contact precautions signage placed in their room to clearly identify required precautions to staff.

A resident exhibited symptoms of COVID-19. Observation two days later, showed a contact precaution sign was posted outside the resident's room. Contact precautions included gown and gloves, which should have included eye protection under droplet/contact precautions.

No eye protection was observed in the personal protective equipment (PPE) caddy outside of the resident's room.

The RPN indicated they had put up the wrong signage, and it should have been the droplet/contact precaution sign. The face shields should also have been put in the caddy outside of the resident's room.

The IPAC lead and the DOC indicated the wrong signage was put up and full PPE, including face shields, should have been provided and used for staff and visitors for resident #001.

There was risk of staff not wearing the appropriate PPE when signage indicating required precautions was posted incorrectly.

Sources: Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes – April 2022, COVID-19 Protocol policy – V4 Infection prevention and control, resident's progress notes; observations of resident's room; interviews with the RPN, IPAC lead, and DOC, and other staff.

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