Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report (A1)

Amended Report Issue Date: June 12, 2024	
Original Report Issue Date: May 31, 2024	
Inspection Number: 2024-1485-0002 (A1)	
Inspection Type: Proactive Compliance Inspection	
Licensee: Belmont House	
Long Term Care Home and City: Belmont House, Toronto	
Lead Inspector Ann McGregor (000704)	**Additional Inspector(s)** Goldie Acai (741521)
Amended By Goldie Acai (741521)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
Compliance Order (CO) #001 Infection Prevention and Control Program' was amended to reflect changes regarding the requirements of the home and the title in relation to one personnel previously listed as a 'PSW' within the Original Licensee report served May 24, 2024.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 3-5, 8-12, 15-16, 2024

The following intake(s) were inspected:

- Intake: #00112366 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee had failed to ensure that the visitor policy was posted in the home.

Rationale and Summary
On a particular day, staff member confirmed that the visitor policy was not posted within the home. This was remedied by the Licensee prior to the conclusion of the inspection. It was observed that the licensee had placed the 'Visitor Policy' on display close the dinning area on the main floor.

Failure to ensure that the visitor policy was posted in the home posed no risk to residents' safety as a result of the non-compliance.

Sources: Observation of policy board on the main floor; and an interview with staff member #110.
[741521]

Date Remedy Implemented: April 12, 2024

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure drugs were stored in an area or a medication cart that was secured and locked.

Rationale and Summary
A medication cart was left unlocked and unattended. A cup with crushed medication was observed unattended on the medication cart. One of the drawers on the medication cart was left open and medications were visible. No residents were observed in the immediate vicinity at the time of this observation. The Registered Practical Nurse (RPN) confirmed the medication cart should not have been left unlocked and unattended when not in use.

Failure to ensure drugs were stored in an area or a medication cart that was secured and locked poses a risk of persons accessing medications not prescribed for them.

Sources: Observation of an unlocked mediation cart; and an interview with RPN and others.
[741521]

WRITTEN NOTIFICATION: Doors in a Home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee has failed to ensure that all doors that residents did not have access to were kept closed and locked.

Rational and Summary
(i) A shower door in the home was observed to be unlocked and able to be opened without the use of a code. The RPN stated they were unaware that the shower door was able to be opened without the use of a code and should have been kept closed and locked.

(ii) A shower door on another unit in the home was observed wide open. The Personal Support Worker (PSW) stated the shower door was left open because staff were unable to unlock the door due to the malfunction of the door's lock. Upon observation with staff, it was found that the shower door locked when closed and

opened with use of a code.

Failure to ensure that all doors that residents did not have access to were kept closed and locked increased the risk of resident entering and injuring themselves while unsupervised.

Sources: Interviews with RPN, and PSW; and observations of doors on the units. [741521]

WRITTEN NOTIFICATION: Doors in a Home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. 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.

The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary
(i) An unlocked supply room was observed containing boxes stacked almost to the ceiling. On the same unit, the door to a second storage room was observed to be held open with an object. There was a sign that read "please keep door closed at all times." The RPN closed and locked both doors on the unit and confirmed that doors leading to non-residential areas should have been kept closed and locked at all

times. At the time of the observation no residents were observed within the immediate vicinity.

(ii) On another home area, the clean linen room, a non-resident area, was observed unlocked with a key in the lock. The Registered Nurse (RN) stated that this key should be removed, as there was shelving inside that could cause injury to residents.

Failure to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff increased the risk of injury to residents.

Sources: Interviews with RPN and RN; and observations of doors on units. [741521]

WRITTEN NOTIFICATION: Windows

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that every window in the home that opens to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres.

Rationale and Summary

An observation was conducted with the Maintenance Supervisor and found the window opening in a resident's room was greater than 15 centimetres (cm).

The Director of Care acknowledged that the window should not open greater than 15 cm and that there was a risk to residents when the window opening exceeded 15 cm.

There was moderate risk to the resident when the window opening in the resident's room exceeded 15 cm.

Sources: Inspector 000704's observation with Maintenance Supervisor, interviews with Maintenance Supervisor and DOC.
[000704)

WRITTEN NOTIFICATION: Pain management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that a resident's response to the effectiveness of the pain management strategies, were monitored.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure the pain management program, at a minimum, focuses on communication and

assessment methods for resident who were unable to communicate their pain, and the effectiveness of the pain management strategies.

Specifically, the registered staff did not comply with the home's policy "Pain Management Program," dated April, 2018, after administration, to determine if pain strategies were effective.

Rationale and Summary
During a medication observation, pain medication was administered to a resident. No reassessment of the resident's pain was completed after the medication was administered.

As per the home's policy, Pain Management Program, V2-Resident Care, revised April, 2018, registered staff were to evaluate if pain strategies were effective and whether changes were required to the care plan.

The RPN acknowledged that they did not reassess the effectiveness of pain medication after administration to the resident.

The DOC acknowledged that staff were required to reassess the effectiveness of pain medication after administration to residents.

Failure to reassess the resident's pain medication after administration poses a risk of not knowing the effectiveness of the medication.

Sources: Inspector's observation to resident, Home's Pain Management Program Policy V2-Resident Care, revised April 2018, interviews with RPN and DOC. [000704]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Re-educate two maintenance staff members on the home's infection prevention and control policy, specifically on when to perform hand hygiene.

2) Re-educate one private companion on the home's infection prevention and control policy, specifically on when to perform hand hygiene, when and if they return to work.

3) Re-educate one PSW, on the home's Routine Practice Policy, specifically on when to perform hand hygiene.

4) Re-educate one PSW, and two maintenance staff on donning and doffing practices within the home's 'Isolation Protocol Policy'.

5) Re-educate one private companion on donning and doffing practices within the home's 'Isolation Protocol Policy,' when and if they return to work.

6) Document the education from steps one, two, and three and maintain a record, to include the date, content, who facilitated the education, and signed staff attendance.

7) Conduct random audits, at a minimum twice weekly, for a period of four weeks following the service of this order including but not limited to:

i) One PSW and two maintenance staff members compliance with the home's hand hygiene program. Include the same private companion mentioned above, if present and working within the facility when audits are being conducted.

ii) One PSW and two maintenance staff members donning and doffing PPE as per the home's Isolation Protocol policy. Include the same private companion mentioned above, if present and working within the facility when audits are being conducted.

8) Maintain a record of the audits from step six, including but not limited to, date of audit, person completing the audit, location audited, staff audited, outcome and actions taken as a result of any deficiencies identified.

Grounds

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

The IPAC lead failed to ensure that there was in place Routine Practices and Additional Precautions in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022." Specifically, the IPAC lead did not ensure the proper use of Personal Protective Equipment (PPE) and hand hygiene practices as required under the IPAC Standard, "Additional Requirement 9.1."

Rationale and Summary

(i) On a particular day, a private companion exited a resident's room, doffed their PPE in receptacle in hallway but failed to perform hand hygiene. They retrieved an item, returned to the resident's room, did not donn their PPE and failed to perform hand hygiene after exiting the room a second time.

The home's IPAC policy directed staff on donning and doffing procedures. The private companion was unaware of this policy; however, they acknowledged that donning and doffing of PPE should have been done as per IPAC practice.

The RPN and IPAC Lead both stated that the private companion should not have gone into the resident's room without wearing the required PPE.

(ii) On the same day, the PSW was observed exiting a resident room while doffing their PPE. In an attempt to access a wall mounted alcohol-base hand rub (ABHR), they reached over a clean supply of PPE. The PSW said they were not familiar with the home's IPAC policy of donning and doffing. Additionally, PSW stated there were no risks when they came into contact with the clean PPE supply while wearing their soiled PPE.

(iii) On another day, the Maintenance staff was observed wearing full PPE while walking in the hallway. They waited beside the maintenance cart before entering a resident's, room that was on IPAC precautions. A short while later the maintenance staff exited the same room, walked across the hallway toward their maintenance cart wearing full PPE, doffed a part of their PPE and placed it on top of their cart. The Maintenance staff was observed touching various items on the cart and did not perform hand hygiene.

The home's isolation policy last revised August 2023, states 'avoid touching other people, objects, touching your own eyes, nose or mouth until after removing PPE and cleaning hands.' The Maintenance staff stated they were trained when they first started their roles, but they were not familiar with all IPAC procedures, and were not aware of the risks to residents if the home's IPAC policy was not followed.

(iv) On the same day, a second Maintenance staff was observed exiting an isolation room wearing PPE. They touched various items on their maintenance cart and opened a drawer before they returned to the resident's room with an item from the cart. The Maintenance staff did not remove their PPE after exiting the resident's environment or perform hand hygiene during this observation.

The Maintenance staff acknowledged being unaware that PPE should be doffed upon leaving a resident's room on precautions.

The IPAC Lead acknowledged doffing should be completed while inside the resident's and hand hygiene should always be performed during the four moments at a minimum to prevent disease transmission.

Failure to implement any standard or protocol with respect to infection prevention and control increased the risk of disease transmission.

Sources: Interviews with the private companion, a PSW, an RPN, the IPAC Lead, and the maintenance staff; observation of the private companion, a PSW, and maintenance staff; and record reviews of the homes policy 'Isolation Protocol-contact/droplet/additional precautions,' last revised August 2023, and the 'Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes,' last revised September 2023.
[741521]

Rationale and Summary
(v) The inspector observed a PSW exiting a resident's room wearing PPE carrying dirty linen. The PSW placed the dirty linen in the linen hamper, doffed their PPE, and discarded them in the garbage receptacle. The PSW failed to perform hand hygiene after doffing their PPE. They then walked towards the clean linen cart, retrieved clean sheets, then proceeded to re-enter the resident's room without performing hand hygiene.

The PSW acknowledged that they did not follow the home's Routine Practice policy when they failed to perform hand hygiene after doffing their PPE.

The home's Routine Practice Policy directed staff to wash hands according to the four moment of hand hygiene.

The DOC advised that staff should have perform hand hygiene after doffing, and before touching clean linen. They acknowledged that there was a risk of transferring micro-organism from one resident to another when staff did not follow the home's Routine Practice policy.

There was risk of infection transmission when staff failed to complete hand hygiene following the doffing of PPE and before retrieving clean linen.

Sources: Home's IPAC policy, Routine Practices, Volume 4, revised February 2024, Inspector 000704's observation, interviews with PSW, DOC and other staff. [000704]

This order must be complied with by July 5, 2024

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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