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

Original Public Report

Report Issue Date: September 4, 2024

Inspection Number: 2024-1485-0003

Inspection Type:
Critical Incident
Follow up

Licensee: Belmont House

Long Term Care Home and City: Belmont House, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14-16, 20-22, 2024

The following intake(s) were inspected in this Follow Up Inspection:

- Intake: #00117625 - Infection Prevention and Control (IPAC)

The following intake(s) were inspected in this Critical Incident (CI) Inspection:

- Intake: #00107596 [CI: 2985-000001-24] - related to a disease outbreak
- Intakes: #00119805 [CI: 2985-000004-24] and #00120395 [CI: 2985-000005-24] - related to an injury of unknown cause

Previously Issued Compliance Order(s)

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

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Order #001 from Inspection #2024-1485-0002 related to O. Reg. 246/22, s. 102 (2) (b) inspected

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident was reassessed at least weekly when they exhibited an altered skin integrity.

Rationale and Summary
A resident exhibited altered skin integrity from the use of a device. The resident's altered skin integrity was not assessed for a specified date. Furthermore, the assessments before and after the specified date had indicated the altered skin integrity had enlarged.

A Nursing Supervisor indicated that staff were required to do a wound assessment at least once per week and a reminder for staff to complete the assessment was scheduled on the Treatment Administration Record (TAR). A Registered Practical Nurse (RPN) confirmed that they had signed the resident's scheduled weekly reminder on the TAR on the specified date, but verified that the assessment was missed.

Failure to reassess the resident at least weekly when they exhibited altered skin integrity increased the risk for staff's inability to monitor the progress and to determine if further interventions were required.

Sources: A resident's clinical records; Interviews with an RPN and a Nursing Supervisor.

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that the scheduled medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
An RPN received an order from the physician for a medication to be given for a

specified time and dates for a resident's condition. The order was entered on the Medication Administration Record (MAR) to administer the medication for a different time and dates from the physician's order. The RPN had corrected the order on the MAR to administer the medication at the correct time and dates as per the physician's order the next day. However, a review of the resident's MAR indicated that two doses were not administered as the order was initially transcribed at the incorrect timing.

An RPN confirmed that two doses were missed as the initial order did not provide the prompt to administer the medication. The Director of Care (DOC) acknowledged that the medication was not administered to the resident in accordance with the directions due to the transcription error.

The transcription error of entering the physician's order to the resident's MAR led to two missed scheduled doses.

Sources: A resident's clinical records; Interviews with an RPN and DOC.