Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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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
May 9, 2019	2019_771609_0001	003131-19	Follow up

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

CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 29 to May 3, 2019.

The following intakes were inspected upon during this Follow up inspection:

-One intake related to Compliance Order (CO) #001 that was issued during inspection #2019_462600_0001 for section (s.) 36. of Ontario Regulation (O. Reg.) 79/10, specific to the home ensuring that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident inspection #2019_771609_0002 was conducted concurrently with this inspection.

PLEASE NOTE: Non-compliance related to s. 6. (1) (a) of the Long Term Care Homes Act (LTCHA), 2007, identified in concurrent inspection #2019_771609_0002 was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Assistant Director of Care (ADOC), Director of Support Services, Director of Programs, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), volunteers and residents.

The Inspector(s) also conducted a daily tour of the resident care areas, reviewed relevant resident care records, home policies as well as staff to resident interactions and the provision of care.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2019_462600_0001	609

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #001, resident #004 and all other residents of the home that utilized a specified intervention, set out the planned care for the resident.

On February 5, 2019, the home was issued a Compliance Order (CO) #001 during inspection 2019_462600_0001 related to section (s.) 36 of Ontario Regulation (O. Reg.) 79/10, with a compliance due date (CDD) of March 15, 2019.

CO #001 stated that the licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically the licensee must have ensured resident #001, resident #002 and any other residents' plans of care regarding their ability and needs for transfer and positioning were up to date.

a) On two particular days, resident #001 was observed by Inspector #609 ambulating with their mobility aid with the specified intervention applied.

A review of resident #001's plan of care found that the resident was to have the specified intervention in place.

A review of resident #001's health care records found in progress notes described that the resident had a specified number of falls between a particular time frame and found

that during one of the falls the specified intervention was not enabled when the resident fell. The specified intervention was fixed and staff were reminded to ensure that the specified intervention was enabled.

During interviews with Personal Support Worker (PSW) #105 and #106, both indicated that on every shift (day, evening and night) residents' specified intervention was to be checked to ensure that it was enabled. The PSWs further indicated that the specified intervention checks were a standard practice and not documented anywhere in the home's records.

A review of the home's policy titled "Documentation- Plan of Care" last reviewed March 2018 indicated that every resident would have a plan of care that set out the planned care for the resident.

A review of resident #001's plan of care found no mention that the resident's specified intervention was to be checked every shift to ensure that it was enabled.

b) A Critical Incident (CI) report was submitted by the home to the Director which outlined how on a particular day, resident #004 fell. The resident was taken to hospital and diagnosed with an injury.

i) The CI report also outlined that prior to the fall, resident #004 had the specified intervention in place.

A review of resident #004's plan of care by Inspector #609 found no mention that the resident's specified intervention was to be checked every shift to ensure that it was enabled.

ii) A review of resident #004's health care records by Inspector #609 found in a progress note that the specified intervention was applied to the resident's mobility aid on a particular day.

On a particular day, the Inspector observed resident #004 with the specified intervention enabled.

A review of resident #004's plan of care found no mention that the resident was to have the specified intervention enabled.

During an interview with the Director of Care (DOC), the lack of direction for staff to check that the specified intervention was enabled, as well as lack of documentation of the checks was reviewed. The DOC indicated that the specified intervention should be documented and that they would be setting up a Point of Care (POC) task to ensure the specified intervention was set out in the residents' plans of care. [s. 6. (1) (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 written plan of care for resident #001, resident #004 and all other residents of the home that utilized the specified intervention set out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001, #003 as well as any other resident of the home who utilized a specified accessory were not restrained for the convenience of the licensee or staff.

On February 5, 2019, the home was issued CO #001 during inspection 2019_462600_0001 related to s. 36 of O. Reg. 79/10, with a CDD of March 15, 2019.

CO #001 stated that "The licensee must be complaint with O. Reg. 79/10, s. 36. Specifically the licensee must: a) Ensure that staff use safe transferring and positioning techniques, as per the residents' plans of care…" Resident #001 was one of the residents specified in CO #001.

a) On a particular day, Inspector #609 observed resident #001 with their specified accessory arranged in an identified manner. The resident was observed unable to move. When asked if they were able to rearrange their specified accessory, resident #001 stated they could not.

A review of resident #001's plan of care indicated that the resident was allowed to move about on the unit. There was no direction in their plan of care to arrange the resident's specified accessory in the identified manner.

During an interview with student PSW #103, they verified that resident #001 was unable to rearrange the manner of their specified accessory without assistance. The PSW indicated that they had gone on their work break and had arranged the resident's specified accessory in the identified manner while they were off the unit.

A review of the home's policy titled "Minimizing Restraints: Use of Restraints" last revised May 2018 defined physical restraints as "any physical or mechanical device to restrain the movement of the whole, or portion of, a resident's body as a means of controlling physical activities". The policy further outlined that every resident had the right not to be restrained, except in the limited circumstances provided for under the Act.

During an interview with PSW #105 (PSW #103's preceptor), they verified that resident #001 was permitted to move about on the unit with their specified accessory and student PSW #103 should not have arranged the specified accessory in the identified manner.

b) On a particular day, Inspector #609 observed resident #003 with their specified accessory arranged in the identified manner. The resident was observed unable to move.

A review of resident #003's plan of care found no direction to staff to arrange their specified accessory in the identified manner.

During an interview with Registered Nurse (RN) #102, they verified that resident #003 was able to move with their specified accessory independently. Together with RN#102, the resident was asked if they could rearrange their specified accessory. The resident was unable to rearrange their specified accessory without assistance.

During the same interview, RN #102 stated "we don't even think about it" when asked why resident #003's specified accessory was arranged in the identified manner and further stated "I never saw it as restraining the resident".

c) On a particular day, at a particular time, Inspector #609 conducted a tour of all five units within the home and found 23 residents, in five separate units, with their specified accessory arranged in the identified manner.

During an interview with PSW #109, they indicated that once a resident was with their specified accessory and placed somewhere they would arrange it in the identified manner so that the resident would not move from where they left them.

During an interview with Registered Practical Nurse (RPN) #108, they verified that residents' specified accessory were being arranged in the identified manner by staff and that there was no direction in any plan of care for any resident to do this.

During an interview with the DOC, they verified that there was not a single plan of care of any resident in the home that directed staff to arrange their specified accessory in the identified manner. The DOC then indicated that they would be re-educating their staff since arranging the specified accessory in the identified manner was considered a restraint if the resident was able to move with it on their own. [s. 30. (1) 1.]

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 resident #001, #003 as well as any other resident of the home who utilized the specified accessory was not restrained for the convenience of the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that they complied with every order made under the Act or regulation.

On February 5, 2019, the home was issued CO #001 during inspection 2019_462600_0001 related to s. 36 of O. Reg. 79/10, with a CDD of March 15, 2019.

CO #001 stated that the licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically the licensee must have ensured resident #001 and #002 and any other residents' plans of care regarding residents' ability and needs for transfer and positioning were up to date. The order further specified that nursing staff were to have ensured identified triggers for responsive behaviour that affected the provision of care to resident #002 and any other residents that exhibited responsive behaviour, were documented in the resident's written plan of care.

a) On a particular day, Inspector #609 observed two specific interventions applied to

resident #001's bed.

A review of resident #001's plan of care directed staff to apply one of the specific interventions to the resident's bed.

A review of the home's policy titled "Documentation- Plan of Care" last revised March 2018 directed staff to update the resident's plan of care when the resident's care needs changed or the care plan was no longer necessary.

During an interview with PSWs #105 and #106, both indicated that resident #001 required the two specified interventions to their bed and not one, as specified in the resident's plan of care.

b) Inspector #609 reviewed resident #001's plan of care which directed staff to provide a specified set of interventions to the resident with the resident's assistance at times.

A review of resident #001's specified set of interventions report from POC for a particular six day review period, found that the resident was not provided the specified set of interventions as per their morning schedule three of the six or 50 per cent of the days reviewed. The resident was not provided the specified set of interventions as per their afternoon schedule one of the six or 16 per cent of the days reviewed.

During interviews with PSW #105 and #106, both indicated that resident #001 most assisted with the specified set of interventions. They then described how the resident would exhibit responsive behaviours if the resident did not provide assistance with the specified set of interventions.

A review of the home's policy titled "Responsive Behaviour Management" last revised October 2016 indicated that behavioural triggers that may result in responsive behaviours would have written strategies to address these behaviours in the resident's plan of care.

A review of resident #001's plan of care found no mention of the resident's responsive behaviours when they did not provide assistance with the specified set of interventions.

During the same interview with PSW #106, a review of resident #001's plan of care was conducted. The PSW verified that the resident's specified set of interventions as well as no identification of their behavioural trigger for responsive behaviours, did not reflect the

resident's care needs.

During an interview with the DOC, a review of the Inspector's observations of resident #001, their plan of care as well as the interviews with PSW #105 and #106 were conducted. The DOC verified that the use of two specified interventions instead of one should have been identified in the resident's plan of care. The DOC also verified that the resident was able assist with the specified set of interventions and the identified trigger for responsive behaviours should have been documented in the resident's plan of care. [s. 101. (3)]

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 they complied with every order made under the Act or regulation, to be implemented voluntarily.

Issued on this 9th day of May, 2019

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

Original report signed by the inspector.