Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

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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
Mar 22, 2022	2022_781729_0006	016591-21, 017365-21, 017958-21, 003984-22	Complaint

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

KIM BYBERG (729), JESSICA BERTRAND (722374)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 15-18, 2022.

The following intakes were completed within the complaint inspection:
-Log #003984-22 related to nutrition care and hydration practices;
-Log #016591-21 related to an allegation of neglect and to the plan of care of a resident;
-Logs #017958-21 and #017365-21 related to fall prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, Dietary Supervisor, Registered Nurse (RN), Personal Support Workers (PSW), Health Care Aide, Dietary Aide, Housekeeping, Residents and Families.

During the inspection, inspector(s) toured the home, observed residents and the care provided to them, reviewed relevant clinical records, relevant policies and other pertinent documents, and observed the general maintenance, cleanliness, safety and infection prevention and control practices of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 VPC(s)
0 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 the care set out in the plan of care for a resident was based on the needs and preferences of that resident.

A complaint was submitted to the Ministry of Long-Term Care that included concerns of staff not positioning a resident properly.

A health professional recommended specific positioning at specific times. The plan of care did not include these directions for staff. The DOC confirmed these interventions should have been documented in the care plan.

When the resident’s care plan did not include the recommended positioning instructions, there was a risk that the wrong interventions would be implemented by staff and result in an adverse reaction.

Sources: A resident's plan of care, progress notes and paper chart, interview with DOC, and Health Professional recommendations. [s. 6. (2)]

2. The licensee has failed to ensure that a resident received their medications in their preferred way as per their plan of care.

A complaint was received by the MLTC related to multiple care concerns for a resident, specifically related to their medication preferences.

The resident's special instructions on their plan of care stated that they received their medications in a specific manner. The staff did not administer these medications as per their preference.

Not providing medication in the correct way may have posed a safety risk for the resident.

Sources: Interview with DOC, and RN, record review of a resident's progress notes and plan of care. [s. 6. (7)]

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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that prescribed medications were administered to a resident in accordance with the directions specified by the prescriber.

A complaint was received by the MLTC related to multiple care concerns for a resident, specifically related to medication administration.

A resident required the administration of a prescribed medication. On a specific date, the resident did not receive their scheduled medication because the physician order had been stopped in the home's electronic medication administration record system (eMAR).

As a result of the physician order not being transcribed into the home’s eMAR system correctly there was a risk of harm to the resident when they did not receive their prescribed medication on a specified date.

Sources: Interviews with DOC and registered staff, record review of resident progress notes, eMAR, medication incident report, Belmont House complaint log, and Physician order. [s. 131. (2)]

Issued on this 23rd day of March, 2022

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

Original report signed by the inspector.