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: February 1, 2024

Inspection Number: 2024-1485-0001

Inspection Type:
Critical Incident
Follow up

Licensee: Belmont House

Long Term Care Home and City: Belmont House, Toronto

Lead Inspector	**Inspector Digital Signature**
Irish Abecia (000710)	Irish J Abecia Digitally signed by Irish J Abecia Date: 2024.02.01 15:40:21 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 19, 23-26, 2024

The following intake was inspected in this Follow-Up inspection:

- Intake: #00101388 - Follow-up related to a previously issued Compliance Order (CO)

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00105071 [CI: 2985-000023-23] - Fall of a resident
- Intake: #00105382 [CI: 2985-000024-23] - Disease outbreak

The following intakes were completed in this CI inspection:

- Intakes: #00091992 [CI: 2985-000013-23/ 2985-000014-23], #00094586 [CI: 2985-000015-23/2985-000016-23], #00096173 [CI: 2985-000017-23], and #00101041 [CI: 2985-000022-23] - Disease outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1485-0004 related to FLTCA, 2021, s. 6 (7) inspected by Irish Abecia (000710)

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control were implemented.

The licensee failed to ensure that the hand hygiene program for residents was followed by staff members in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard), revised September 2023. Specifically, residents were not assisted to perform hand hygiene before meals as required by Additional Requirement 10.2 (c) under the IPAC standard.

Rationale and Summary
On a specific date, staff on a resident home area assisted residents to their designated seats in the dining room. Staff that were present in the room were observed not assisting several residents with performing hand hygiene prior to the meal service.

A Registered Nurse (RN) confirmed that they did not observe staff assisting residents with performing hand hygiene prior to the meal service. The IPAC Lead verified that staff should be assisting residents with cleaning their hands prior to meals.

Failure to ensure that residents were assisted in performing hand hygiene before meals increased the risk of infection transmission.

Sources: Observations; interviews with IPAC Lead and an RN

[000710]