



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

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

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité**

Toronto Service Area Office  
5700 Yonge Street, 5th Floor  
TORONTO, ON, M2M-4K5  
Telephone: (416) 325-9660  
Facsimile: (416) 327-4486

Bureau régional de services de  
Toronto  
5700, rue Yonge, 5e étage  
TORONTO, ON, M2M-4K5  
Téléphone: (416) 325-9660  
Télécopieur: (416) 327-4486

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 3, 2013	2013_157210_0027	T287-13	Critical Incident System

**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**

SLAVICA VUCKO (210)

**Inspection Summary/Résumé de l'inspection**



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

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

---

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): November 28 and 29, 2013**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Assistant Director of Care (ADOC), Physiotherapist (PT), Director of Care (DOC)**

**During the course of the inspection, the inspector(s) observed provision of care, reviewed clinical records**

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

**Critical Incident Response**

**Falls Prevention**

**Personal Support Services**

**Findings of Non-Compliance were found during this inspection.**

---

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

---

<b>Legend</b>	<b>Legendé</b>
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**

**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**

**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**

**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

---

**Findings/Faits saillants :**



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

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

---

1. The licensee failed to ensure that the resident plan of care is reviewed and revised when Resident #1 care needs related to transfer changed from one to two person assist.

Review of Resident #1's clinical record indicates the resident had a fall in spring 2013, was sent to hospital and came back the following day. Review of hospital discharge documents confirms Resident #1 was diagnosed with fractures. Review of the written plan of care prior to hospitalization in relation to transfer for Resident #1 indicates resident to be provided one person extensive guidance and physical assistance. Interview with an identified staff indicates when Resident #1 came back from hospital was assessed and it was verbally communicated to day shift staff that Resident #1 transfer status changed from one to two person assist, with special instructions for the transfer. Resident's plan of care was not reviewed and revised after his/her return from the hospital to capture the change in resident's needs.[s.6.(10)(b)]

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

---

**Findings/Faits saillants :**



---

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including reassessments, interventions and the resident's responses to interventions are documented.

Review of clinical record indicates that several days before Resident #1 was sent to hospital because of a fall she/he was assessed and several medications were put on hold. Review of clinical notes confirms an identified staff communicated the change in treatment with SDM the same day. Because of SDM concern to treatment change it was agreed with staff that the resident response would be monitored. Review of Resident #1's clinical record and interview with identified staff confirmed that the resident was not monitored and the resident's responses to the interventions were not documented.

Review of Resident#1's clinical record and interview with identified staff confirm the assessment completed when Resident#1 came back from hospital related to the method and level of assistance for transfer was not documented. Assessment was documented several days after it was completed as a late entry.[s.30(2)]

---

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following:**

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

---

**Findings/Faits saillants :**

1. The licensee failed to ensure when the resident has fallen, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of a clinical record and interview with identified staff confirm when Resident #1 had a fall in spring 2013 a post-fall assessment has not been conducted using a clinically appropriate assessment instrument designed for falls. [s. 49. (2)]



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

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

---

---

**Issued on this 3rd day of December, 2013**

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

SLAVICA UCKO