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

Division des foyers de 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
Feb 5, 2019	2019_462600_0001	007126-17, 013762-17	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

GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 2, 3, 4, 7, 8, 2019.

During the inspection the following Critical Incident System reports were inspected:
log #007126-17 - for injury sustained during transfer,
log #013762-17 - for injury sustained during a fall.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Director of Care (ADOC), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Health Care Aid (HCA), and Residents.

During the course of the inspection, the inspector observed staff and residents interactions and provision of care, reviewed clinical health records and relevant policy and procedures.

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

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
4 VPC(s)
1 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe devices or techniques when assisting resident #011 and resident #012.

On an identified date the Ministry of Health and Long Term Care (MOHLTC) received a

report through a critical incident system (CIS) that indicated resident #011 had an incident that caused an injury for which the resident was taken to hospital and which resulted in a significant change in the resident’s condition.

A review of the resident’s progress notes indicated that on a specified date Registered Practical Nurse (RPN) #100 heard an alarm go off and went to check resident #011. The RPN saw the resident self-transferring. The RPN assisted resident #011 with an identified activity of daily living (ADL) during which the resident was not able to participate in part of the activity so the RPN assisted the resident to a safe position. The RPN then activated the alarm and Health Care Aide (HCA) #101 came in to assist in part of the identified ADL of resident #011. The RPN’s note indicated no injury was sustained.

Further review of the progress notes indicated that the resident's condition changed and on an identified date was confirmed the resident had an identified injured body part.

A review of the resident's minimum data set (MDS) assessment record from an identified date indicated that resident #011 needed extensive assistance by two staff for two identified ADL.

A review of the resident's written plan of care, revised on an identified date indicated resident #011 was identified to need assistance by staff for the identified ADL due to recognized changes in their condition. The resident was identified to be at risk for incident and had some interventions in place to be applied at scheduled hours (HRS) and as needed.

An interview with HCA #101 indicated they assisted with the identified ADL to the resident when-ever they have available time, once a shift, unless the resident asks for it.

In an interview, RPN #100 stated that on a specified date, they heard an alarm coming from the resident's area and saw the resident was self-transferring. The RPN assisted the resident with the ADL. The RPN also knew the resident was at risk for incident so they stayed with the resident to complete both ADL. They assisted resident #011 with identified ADL during which the resident was not able to participate in part of the activity so the RPN assisted the resident to a safe position. The RPN stated that this was the only solution they could come up with at that time, although the resident was located between the assistive device and an identified object. Further in the interview the RPN disclosed that they were not regular staff on that unit and they were not so familiar with the resident, but they saw the resident transferring self, so they assumed the resident

was able to participate in the activity. However the RPN acknowledged that they did not use safe technique when assisting the resident with the ADL. The RPN confirmed they should have activated the call bell initially when they got to the resident's area and wait for the HCA to assist the resident with the ADL.

In an interview, the Assistant Director of Care (ADOC) acknowledged that RPN #100 did not use safe techniques while assisting resident #011 in an identified ADL. They also indicated the RPN should have sought assistance from another staff when providing assistance to resident #011 with ADL. [s. 36.]

2. On an identified date, the MOHLTC received a report through a CIS that indicated resident #012 sustained a significant change on an area of a body part during assistance of the staff with ADL.

A review of the home's investigation notes indicated that on a specified date resident #012 told the Registered Nurse (RN) #105 that HCA #107 came in the room while the resident was still in bed, told the resident they would get them ready for meal and assisted the resident with ADL. The resident's statement in the investigation notes also indicated the staff took the resident's identified body parts during the assistance, holding them during the process.

In an interview, RN #105 stated that on a specified date, resident #012 approached the RN and showed them the body part with an identified change. The resident told the RN that the HCA that assisted them with morning care caused the change. The RN indicated that the resident tended to exhibit an identified responsive behaviour in care if they were not familiar with the staff who was to assist them. The RN indicated HCA #107 was not a regular staff on the floor.

A review of resident #012's written plan of care revised on an identified date, and after the incident, did not indicate that the resident was exhibiting identified behaviour during care when they are not familiar with the staff who provide assistance.

In an interview, HCA #107 confirmed they were not regular staff on the floor and were not familiar with the resident. The HCA also stated the RN indicated that resident #012 may have exhibited responsive behaviour during care if not familiar with staff who provide care. The HCA confirmed that while assisting the resident in care during the ADL they held the resident's body parts. Further the HCA stated that the resident was not pleased to be up in the bed, so they did not willingly participate in care, which made the HCA hold

on the resident's body parts tighter than how the HCA would usually provide care.

A review of resident #012’s MDS assessment report from an identified date, indicated the resident had change in condition of identified body parts. They needed extensive assistance by two staff for identified ADL.

A review of resident #012’s written plan of care revised on a specified date, indicated resident #012 was identified as needing assistance for ADL due to change in a condition. Direction given to the staff was to provide two staff extensive assistance for ADL including the identified ADL, as resident could participate in parts of the care. However, when the resident was tired, the staff was directed to use an identified assistive device for the identified ADL.

On an identified date, Inspector #600 observed provision of care to resident #012 conducted by PSW #104. The PSW was observed to assist the resident with identified ADL while the resident was still in bed. The PSW provided one staff extensive assistance on two occasions while providing care. The resident was observed to be upset when they were provided care. After the resident was dressed and ready, with assistance of HCA #106 the resident was transferred using an assistive device.

An interview with PSW #104 indicated they were aware the resident needed two staff assistance for the identified ADL. However, because the other staff were busy, they provided care by themselves. The PSW called the second staff only for assistance with use of an assistive device. During a review of the resident's written plan of care with Inspector #600, and describing resident #012's appearance during the care, the PSW acknowledged that they should have another PSW during care to provide save positioning.

In an interview, RN #105 stated that HCA #107 did not use safe techniques when they assisted resident #012 on the identified date, while providing assistance with identified ADL. Further the RN stated that the PSW should have asked for assistance from the second PSW while providing care to resident #012. RN #105 also confirmed that PSW #104 did not use safe techniques when they assisted resident #012 with care on the identified date.

An interview with the ADOC indicated that the HCA did not provide safe techniques while assisting the resident on an identified date. The ADOC also advised they provided re-education to the staff regarding use of proper techniques while assisting resident #012

with their ADL. As well the ADOC acknowledged that PSW #104 should have waited for the second staff to assist resident #012 in techniques while providing care. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident rights to give or refuse consent to any treatment, care or service were fully respected and promoted.

On an identified date, the MOHLTC received a report through a CIS that indicated resident #012 sustained a significant change of body part during assistance of the staff in ADL.

A review of the home's investigation notes indicated that on a specified date resident #012 told the RN #105 that HCA #107 came in the room while the resident was still in bed, told the resident they would get them ready for breakfast and assisted the resident with ADL.

In an interview, RN #105 stated that on the identified date, resident #012 exhibited an identified responsive behaviour during care if they were not familiar with the staff who was to assist them. The RN indicated HCA #107 was not a regular staff on the floor, and they were notified of the resident's behaviour. However the RN acknowledged that they told the HCA to go back to the resident and tell them they have to get up and have meal.

In an interview, HCA #107 confirmed they were not regular staff on the floor. The HCA confirmed that they approached the resident once to get them up for breakfast and the resident exhibited responsive behaviour. The HCA left the resident and reported to the RN. The RN told the HCA to go again to the resident and tell the resident that they have to get up as they have to have their meal. The HCA went back to the resident and told the resident that they must get the resident up as they had to eat. The HCA confirmed in the interview that the resident was still exhibiting identified behaviour and because the RN told the HCA to get the resident up, the HCA continued to persuade the resident. Further the HCA stated that the resident was not pleased to be up and out of the bed, so they did not willingly participate in the care, which made the HCA hold on the resident's identified body parts tighter which might have caused the changes in an area of the resident's body part. The HCA acknowledged that they did not respect the resident's right to refuse, they wanted to get the work done.

In an interview, the ADOC acknowledged that HCA #107 did not respect the resident rights to refuse so they have re-educated the HCA regarding resident's behaviour and the resident's rights. [s. 3. (1) 11. ii.]

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 residents' rights to give or refuse consent to any treatment, care or service are fully respected and promoted, to be implemented voluntarily.

WN #3: 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).

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 :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

On an identified date the MOHLTC received a report through a CIS that indicated resident #011 had an incident that caused an injury for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the resident's minimum data set (MDS) assessment record from an identified

date indicated that resident #011 needed extensive assistance by two staff for identified ADL.

Review of the resident's post fall huddle and written plan of care indicated that resident #011 was identified to be at risk for incident due to recognized change in condition, and one of the strategies to prevent incidents was for the resident to be assisted for identified ADL by two staff with extensive assistance at identified hrs and as needed.

Review of the HCA daily documentation record for June, indicated that on an identified date in 2017, resident #011 was assisted in ADL at specified hrs with extensive assistance by one staff.

In an interview, HCA #101 indicated that they assisted the resident whenever they had available time because the direction given to the staff in their electronic documentation, point of care (POC) did not specify the time when the resident was to be assisted for the identified ADL. When they reviewed the resident's written plan of care with the inspector, the HCA confirmed that they did not have clear direction as to when to assist the resident, because the guidelines in the documentation record showed only assistance every shift with no indication for a specified time.

In an interview, RN #103 acknowledged that the direct care staff would not know when to assist the resident because they were not directed in POC to assist the resident with the identified ADL at the specific time as it was set in the plan of care after the previous incident. When reviewing the report with the inspector, the RN acknowledged that when the interventions were entered in the resident's written plan of care, the time was not set up for the staff, to give them clear direction as to what time to assist the resident with identified ADL.

An interview with the ADOC confirmed that the staff and others who provided direct care to the resident did not have clear directions as when the resident needed to be assisted with ADL. [s. 6. (1) (c)]

2. The licensee has failed to ensure that when the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of resident #012's MDS assessment record from an identified date indicated the resident needed assistance by staff for an identified ADL.

On an identified date, Inspector #600 observed provision of care to resident #012 conducted by PSW #104. The PSW was observed to assist the resident with an identified ADL while the resident was still in bed. The PSW provided one staff extensive assistance on two occasions while providing care. The resident was observed to be upset when they were cared for. After the resident was dressed and ready, with assistance of HCA #106 the resident was transferred using an assistive device.

A review of resident #012’s written plan of care revised on December 14, 2018, indicated resident #012 was identified to need assistance by two staff for identified ADL due to recognized changes in condition. Direction given to the staff was to provide two staff extensive assistance for transfer, resident can stand and pivot or when they are tired, to use an assistive device. Further review of the resident’s written plan of care indicated that the resident’s need for assistance for an identified ADL was not addressed, and the plan for assistance with another ADL for resident #012, did not give direction to the staff about how many staff was needed to assist the resident.

A review resident #012’s written plan of care, and in an interview, HCA #106 indicated that resident #012 needed total assistance by two staff for all ADL and the resident was not able to use an identified assistive device anymore. The HCA further stated the resident plan of care should have been updated as the written plan of care does not give direction to the staff as per resident #012’s present condition.

An interview with RN #105 indicated that the RN reviewed the resident's written plan of care, but missed to revise it and update.

In an interview the ADOC agreed that resident #012's written plan of care was not revised to reflect the resident’s present condition and interventions for staff to carry out. [s. 6. (10) (b)]

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 plan of care set out clear directions to staff and others who provided direct care to the resident,
- to 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 the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living.

On an identified date the MOHLTC received a report through a CIS that indicated resident #012 sustained a change in identified body parts during providing care by staff.

A review of the resident's MDS assessment record from an identified date indicated, resident #012 had recognized changes in health condition. No indication that the resident had exhibited identified responsive behaviour during care when assisted with ADL.

Further review indicated the resident needed extensive assistance from one staff for ADL including one identified activity.

An interview with RN #105 and the home's investigation notes indicated that on an identified date, resident #012 approached the RN and showed them the resident's body part with an identified change in condition stating that the HCA who assisted with care, caused the change. The resident's statement in the investigation notes also indicated the staff took the resident's body parts to assist them with an identified ADL, then assisted with another identified ADL by holding the resident's identified body parts throughout the process. In the interview the RN indicated that the resident tended to exhibit an identified responsive behaviour during care when they are to get up and out from bed if they are not familiar with the staff who was to assist them with care. The HCA who assisted the resident on the identified date was not a regular staff on the floor.

A review of resident #012's written plan of care revised on an identified date and after the incident, indicated the resident was not identified to need assistance with the identified ADL and was not identified to exhibit an identified responsive behaviour during care when they are not familiar with the staff who provide assistance.

In an interview, HCA #107 confirmed they were not regular staff on the floor and were not aware that resident #012 may be exhibiting the identified behaviour during care when not familiar with staff who was to provide care. The HCA confirmed that while assisting the resident with the identified ADL they held the resident's identified body parts. Further, the HCA stated that the resident was not pleased to be up and out of bed, so they did not willingly participate in the care, which made the HCA hold on to the resident's identified body parts tighter than how the HCA would usually provide care which may have caused the change in the area of the resident body parts.

In an interview and review of resident #012's written plan of care with Inspector #600, RN #105 acknowledged that the resident's written plan of care did not indicate the resident's needs for assistance with ADL, need to be assisted by familiar staff, and risk for exhibiting identified responsive behaviour if the resident was not familiar with the staff.

An interview with the ADOC indicated that the staff is expected to update the resident plan of care every quarter when resident had MDS assessment completed or when there is a change in the resident's condition. The ADOC acknowledged that resident #012's written plan of care was not based on an interdisciplinary assessment of the resident's physical functioning for the identified ADL and the type and level of assistance required

for ADL considering the resident’s trigger for identified responsive behaviour. [s. 26. (3) 7.]

2. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's special treatments and interventions.

A review of the home’s investigation notes indicated that resident #012 told RN #105 that HCA #107 came in the room while the resident was still in bed, told the resident they will get them ready for breakfast and assisted resident with an identified ADL. The resident’s statement in the investigation notes also indicated the staff took the resident’s identified body parts to assist with identified ADL holding the resident’s body parts. Further, in reviewing the investigation notes, it was discovered the resident was on a specified treatment which indicated the resident's condition could be easily altered.

A review of the resident MDS assessment record from an identified date, indicated resident #012 needed extensive assistance from one staff for ADL including an identified ADL. Further the MDS assessment record did not indicate that the resident was on any special treatment for what the resident was to be monitored.

A review of the medication administration record for an identified month in 2017, indicated the resident was on a specified treatment daily. The treatment initially was ordered two years prior to the incident.

A review of resident #012’s written plan of care from an identified date, and after the incident, indicated the resident was not identified to be at risk for altered condition as they were receiving a specified treatment.

In an interview, HCA #107 confirmed that during assisting the resident with ADL in bed and later assisting with another ADL they held the resident’s identified body parts. Further the HCA stated that the resident was exhibiting an identified responsive behaviour during care so they did not willingly participate in their care, which made the HCA hold on to the resident’s identified body parts tighter than how the HCA would usually provide care which further caused resident's body parts to change. The HCA responded that they were not aware that the resident received a treatment that could cause the resident to alter condition easily.

An interview with RN #105 indicated that when updating resident #012’s written plan of care they missed to address the risk for change in condition due to receiving a specified

treatment.

In an interview, the ADOC acknowledged that resident #012's written plan of care does not reflect the resident's identified treatment that would alert the staff to monitor the resident when providing care. [s. 26. (3) 18.]

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 plan of care is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living,
- to ensure that the plan of care is based on an interdisciplinary assessment of the resident's special treatments and interventions, to be implemented voluntarily.

WN #5: 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 has failed to ensure that when the resident has fallen, the resident had been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On an identified date, the MOHLTC received a report through a CIS that indicated that, resident #011 had an incident that caused an injury for which the resident was taken to hospital and which resulted in a significant change in the resident's condition.

A review of the resident’s progress notes from an identified date, indicated resident #011 had an incident during care assisted by RPN #100. The RPN’s note indicated no injury was sustained. No other notes were identified regarding this incident. The RPN considered this incident as a near miss. Further review of the progress notes indicated that the resident's condition changed and a few days later was confirmed that the resident sustained an injury to an identified body part. A documentation in the progress notes by ADOC indicated that near miss was accounted as an incident and that it was the home's eighth incident for the identified month.

A review of resident #011’s clinical record indicated that resident #011 was not assessed from head to toe, critical investigation was not conducted and the huddle was not initiated.

Review of the home’s policy volume 2, revised June 2017, under identified section, among others, give direction to the registered staff after resident had an incident, a Head To Toe assessment to be conducted to determine any injury and take appropriate action based on the assessment, complete an incident investigation including all contributing factors, and complete an identified Huddle in collaboration with interdisciplinary staff to determine the root cause of the incident.

An interview with RPN #100 indicated that on an identified date they assisted resident #011 when the incident happened. The RPN admitted that at that time they did not think it was an incident but a near miss, and treated it as such. Further the RPN stated that they did a head to toe assessment, incident report and a post fall huddle however, further in the interview after reviewing the resident’s clinical record with Inspector #600, the RPN acknowledged that they did not do a head to toe assessment, just noted that there was no injury from what they saw initially. The RPN confirmed that the huddle was not initiated and the critical incident was not done at that time.

An interview with ADOC #102 indicated that expectation of the staff was after each incident a resident has, the staff is to assess the resident using the head to toe tool from the electronic documentation and initiate huddle. The ADOC confirmed that the incident that happened on the identified date, was considered as an incident and a head to toe assessment and a huddle should have been done. After reviewing the resident’s clinical record, the ADOC confirmed that the above mentioned assessments were not in the resident’s health record, indicating that the RPN did not complete those assessments.

In an interview, the DOC acknowledged that when resident #011 had the incident, they

were not assessed and, a huddle assessment was not conducted using a clinically appropriate assessment instrument that is specifically designed for incidents. [s. 49. (2)]

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 when the resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 7th day of February, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GORDANA KRSTEVSKA (600)
Inspection No. / No de l'inspection :	2019_462600_0001
Log No. / No de registre :	007126-17, 013762-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 5, 2019
Licensee / Titulaire de permis :	Toronto Aged Men's and Women's Homes 55 Belmont Street, TORONTO, ON, M5R-1R1
LTC Home / Foyer de SLD :	Belmont House 55 Belmont Street, TORONTO, ON, M5R-1R1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Maria Elias

To Toronto Aged Men's and Women's Homes, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant 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, when assisting residents #011 and #012 and any other residents who need assistance by staff for transfer and repositioning.
b) Ensure resident #011 and #012 and any other residents' plans of care regarding residents' ability and needs for transfer and positioning are up to date.
c) Ensure nursing staff providing care to resident #011 and #012 and any other residents are aware of the residents' plans of care prior to assisting the residents.
d) Ensure nursing staff identify triggers of responsive behaviour that affect the provision of care to resident #012 and any other residents that exhibit responsive behaviour. Document in the resident's written plan of care and communicate the triggers to the staff providing care to the residents.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that staff used safe devices or techniques when assisting resident #011 and resident #012.

On an identified date the Ministry of Health and Long Term Care (MOHLTC) received a report through a critical incident system (CIS) that indicated resident #011 had an incident that caused an injury for which the resident was taken to hospital and which resulted in a significant change in the resident's condition.

A review of the resident's progress notes indicated that on a specified date Registered Practical Nurse (RPN) #100 heard an alarm go off and went to check

resident #011. The RPN saw the resident self-transferring. The RPN assisted resident #011 with an identified activity of daily living (ADL) during which the resident was not able to participate in part of the activity so the RPN assisted the resident to a safe position. The RPN then activated the alarm and Health Care Aide (HCA) #101 came in to assist in part of the identified ADL of resident #011. The RPN's note indicated no injury was sustained.

Further review of the progress notes indicated that the resident's condition changed and on an identified date was confirmed the resident had an identified injured body part.

A review of the resident's minimum data set (MDS) assessment record from an identified date indicated that resident #011 needed extensive assistance by two staff for two identified ADL.

A review of the resident's written plan of care, revised on an identified date indicated resident #011 was identified to need assistance by staff for the identified ADL due to recognized changes in their condition. The resident was identified to be at risk for incident and had some interventions in place to be applied at scheduled hours (HRS) and as needed.

An interview with HCA #101 indicated they assisted with the identified ADL to the resident when-ever they have available time, once a shift, unless the resident asks for it.

In an interview, RPN #100 stated that on a specified date, they heard an alarm coming from the resident's area and saw the resident was self-transferring. The RPN assisted the resident with the ADL. The RPN also knew the resident was at risk for incident so they stayed with the resident to complete both ADL. They assisted resident #011 with identified ADL during which the resident was not able to participate in part of the activity so the RPN assisted the resident to a safe position. The RPN stated that this was the only solution they could come up with at that time, although the resident was located between the assistive device and an identified object. Further in the interview the RPN disclosed that they were not regular staff on that unit and they were not so familiar with the resident, but they saw the resident transferring self, so they assumed the resident was able to participate in the activity. However the RPN acknowledged that they did

not use safe technique when assisting the resident with the ADL. The RPN confirmed they should have activated the call bell initially when they got to the resident's area and wait for the HCA to assist the resident with the ADL.

In an interview, the Assistant Director of Care (ADOC) acknowledged that RPN #100 did not use safe techniques while assisting resident #011 in an identified ADL. They also indicated the RPN should have sought assistance from another staff when providing assistance to resident #011 with ADL. [s. 36.]
(600)

2. 2. On an identified date, the MOHLTC received a report through a CIS that indicated resident #012 sustained a significant change on an area of a body part during assistance of the staff with ADL.

A review of the home's investigation notes indicated that on a specified date resident #012 told the Registered Nurse (RN) #105 that HCA #107 came in the room while the resident was still in bed, told the resident they would get them ready for meal and assisted the resident with ADL. The resident's statement in the investigation notes also indicated the staff took the resident's identified body parts during the assistance, holding them during the process.

In an interview, RN #105 stated that on a specified date, resident #012 approached the RN and showed them the body part with an identified change. The resident told the RN that the HCA that assisted them with morning care caused the change. The RN indicated that the resident tended to exhibit an identified responsive behaviour in care if they were not familiar with the staff who was to assist them. The RN indicated HCA #107 was not a regular staff on the floor.

A review of resident #012's written plan of care revised on an identified date, and after the incident, did not indicate that the resident was exhibiting identified behaviour during care when they are not familiar with the staff who provide assistance.

In an interview, HCA #107 confirmed they were not regular staff on the floor and were not familiar with the resident. The HCA also stated the RN indicated that resident #012 may have exhibited responsive behaviour during care if not

familiar with staff who provide care. The HCA confirmed that while assisting the resident in care during the ADL they held the resident's body parts. Further the HCA stated that the resident was not pleased to be up in the bed, so they did not willingly participate in care, which made the HCA hold on the resident's body parts tighter than how the HCA would usually provide care.

A review of resident #012's MDS assessment report from an identified date, indicated the resident had change in condition of identified body parts. They needed extensive assistance by two staff for identified ADL.

A review of resident #012's written plan of care revised on a specified date, indicated resident #012 was identified as needing assistance for ADL due to change in a condition. Direction given to the staff was to provide two staff extensive assistance for ADL including the identified ADL, as resident could participate in parts of the care. However, when the resident was tired, the staff was directed to use an identified assistive device for the identified ADL.

On an identified date, Inspector #600 observed provision of care to resident #012 conducted by PSW #104. The PSW was observed to assist the resident with identified ADL while the resident was still in bed. The PSW provided one staff extensive assistance on two occasions while providing care. The resident was observed to be upset when they were provided care. After the resident was dressed and ready, with assistance of HCA #106 the resident was transferred using an assistive device.

An interview with PSW #104 indicated they were aware the resident needed two staff assistance for the identified ADL. However, because the other staff were busy, they provided care by themselves. The PSW called the second staff only for assistance with use of an assistive device. During a review of the resident's written plan of care with Inspector #600, and describing resident #012's appearance during the care, the PSW acknowledged that they should have another PSW during care to provide save positioning.

In an interview, RN #105 stated that HCA #107 did not use safe techniques when they assisted resident #012 on the identified date, while providing assistance with identified ADL. Further the RN stated that the PSW should have asked for assistance from the second PSW while providing care to resident

#012. RN #105 also confirmed that PSW #104 did not use safe techniques when they assisted resident #012 with care on the identified date.

An interview with the ADOC indicated that the HCA did not provide safe techniques while assisting the resident on an identified date. The ADOC also advised they provided re-education to the staff regarding use of proper techniques while assisting resident #012 with their ADL. As well the ADOC acknowledged that PSW #104 should have waited for the second staff to assist resident #012 in techniques while providing care. [s. 36.]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #011. The scope of the issue was a level 2 as it related to two of three residents inspected. The home had a level 2 history as they had unrelated non-compliance in last three years. (600)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 15, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of February, 2019

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Gordana Krstevska

Service Area Office / Bureau régional de services : Toronto Service Area Office