

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: November 8, 2023	
Inspection Number: 2023-1485-0004	
Inspection Type: Critical Incident	
Licensee: Belmont House	
Long Term Care Home and City: Belmont House, Toronto	
Lead Inspector Cindy Cao (000757)	Inspector Digital Signature
Additional Inspector(s) Cindy Ma (000711) Christine Francis, was also present during this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 25-27, 2023 and October 30, 2023

The following intake(s) were inspected:

Intake #00088704/Critical Incident (CI)#2985-000009-23 - related to unknown cause of injury
Intake #00090926/CI#2985-000011-23 - related to falls prevention and management

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

- Resident Care and Support Services
- Infection Prevention and Control
- Falls Prevention and Management

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Pain management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure a resident was assessed using a clinically appropriate assessment instrument when their pain was not relieved by initial interventions.

Rationale and Summary

Progress notes indicated that a resident complained of pain on one occasion. As a result of this, pain medication was administered for pain by a Registered Practical Nurse (RPN). Review of the pain reassessment record completed by the RPN indicated that the resident's pain was not relieved by the initial intervention. No other assessment was completed, or action taken to address the resident's unrelieved pain.

The RPN and Director of Care (DOC) both acknowledged that a pain assessment should have been completed when the resident's pain was not relieved by the initial intervention.

Failure to ensure the resident's pain was assessed using a clinically appropriate assessment instrument after initial interventions were ineffective lead to the resident having unrelieved pain.

Sources: A resident's clinical record and interviews with staff.

[000711]

COMPLIANCE ORDER CO #001 Plan of Care

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:

- 1) Re-train one Personal Support Worker (PSW) on the home's Falls Prevention and Management policy. In addition, review with the PSW their role and responsibility in ensuring that falls prevention and management interventions, including specific devices are implemented for residents.
- 2) Document the education from step 1 and maintain a record, to include the date the date and the staff

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member who provided the education.

3) Conduct random audits, for a minimum of two weeks following service of this order, of a resident's device to ensure it is in use when the resident is up in the wheelchair.

4) Maintain a record of the audits conducted, to include, but not limited to: audit dates, person(s) completing the audits, audit findings and any actions taken in response to the audit findings.

Grounds

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan of care.

Rationale and Summary

A resident was identified as risk for falls. The resident's plan of care stated that they required a specific device when in the wheelchair as part of their falls prevention interventions.

On one occasion, the resident sustained a fall. They were subsequently hospitalized and found to have sustained injuries.

A PSW admitted that they did not apply the device to the resident's wheelchair prior to their fall. The PSW acknowledged that the device should have been applied when the resident was in the wheelchair.

A Registered Nurse (RN) and the DOC both acknowledged that the device should have been applied when the resident was in the chair.

Failure to apply the specific device put the resident at risk for injuries and a delayed staff response.

Sources: A resident's clinical records and interviews with staff.

[000757]

This order must be complied with by December 20, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

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Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

In the last 36 months, a compliance order was issued under LTCHA, 2007, s. 6 (7) on January 14, 2022 under inspection # 2021_846665_0007.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
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Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.