Ontario

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
May 9, 2019	2019_771609_0002	006423-18, 009145-18, 019276-18	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

CHAD CAMPS (609)

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): April 29 to May 3, 2019.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

-Two intakes related to infectious outbreaks within the home; and
-One intake related to a resident who fell, was taken to the hospital and diagnosed with an injury.

A Follow-Up inspection #2019_771609_0001 was conducted currently with this CIS inspection.

PLEASE NOTE: Non-compliance related to s. 6. (1) (a) of the LTCHA, 2007, was identified in this inspection and has been issued in inspection report #2019_771609_0001, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Assistant Director of Care (ADOC), Director of Support Services, Director of Programs, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), volunteers and residents.

The Inspector(s) also conducted a daily tour of the resident care areas, reviewed relevant resident care records, home policies as well as staff to resident interactions and the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Two Critical Incident System (CIS) reports were submitted to the Director related to outbreaks of infectious illness within the home.

On a particular day, while conducting a tour of the home, Inspector #609 observed an identified intervention applied to resident #005 and #006. There was no indication why the residents required the identified intervention.

During an interview with RN #102, they stated that residents #005 and #006 were experiencing specific symptoms over a specific time frame and required the identified intervention.

A review of the home's tracking document of the specified symptoms identified resident #005 and #006 as requiring the identified intervention.

A review of the home's policy titled "Isolation Procedures- precautionary measures" last revised November 2018 required an additional intervention be provided, which the Inspector did not observe.

During an interview with the Assistant Director of Care (ADOC), they verified that the additional intervention was supposed to be implemented and that this did not occur for residents #005 and #006. [s. 229. (4)]

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Issued on this 9th day of May, 2019

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

Original report signed by the inspector.