

**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

<b>Amended Public Report (A1)</b>	
<b>Amended Report Issue Date:</b> May 18, 2023	
<b>Original Report Issue Date:</b> May 16, 2023	
<b>Inspection Number:</b> 2023-1485-0003 (A1)	
<b>Inspection Type:</b> Complaint Critical Incident System	
<b>Licensee:</b> Toronto Aged Men's and Women's Homes	
<b>Long Term Care Home and City:</b> Belmont House, Toronto	
<b>Lead Inspector</b> Goldie Acai (741521)	<b>Additional Inspector(s)</b>
<b>Amended By</b> Goldie Acai (741521)	<b>Inspector who Amended Digital Signature</b>

## AMENDED INSPECTION SUMMARY

This report has been amended to:  
This licensee inspection report has been revised to reflect the new information submitted by the licensee. The inspection 2023-1485-0003 was completed on May 9, 2023.

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1-5, 8-9, 2023.

The following intakes were completed in this Critical Incident (CI) inspection:  
Intake #00021050/CI#2985-000002-23 was related to unwitnessed falls.  
Intake #00021060/CI#2985-000003-23 and Intake #00021638/CI#2985-000004-23 were related to unknown cause of fracture; and  
Intake #00006035/CI#2985-000005-22 was related to improper transferring/positioning.

The following intake was completed in this Complaint inspection:  
Intake #00085416 was related to communication methods, whistle-blower protection,

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dealing with complaints, continence care, nursing and personal care support services, and therapy services.

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

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

## AMENDED INSPECTION RESULTS

### WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a 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 change or care set out in the plan was no longer necessary.

#### **Rationale and Summary:**

A sign was observed posted in a resident's room indicating an intervention was required to prevent injury 24 hours a day. The care plan stated the intervention was only required at particular times of the day. The registered practical nurse (RPN) indicated that the resident had previously conditions that would necessitate the need for this intervention, but this has since been resolved. The Director of Care (DOC) indicated this intervention should have been updated as the impact of not doing so was that inconsistent care would be provided by staff.

Failure to update the care plan increased the risk of improper care being provided to residents.

Sources: Record review of resident's care plan; observations; interview with the DOC and RPN #108.

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## WRITTEN NOTIFICATION: Duty to Protect

### NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from neglect by the staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

#### Rationale and Summary:

A personal support worker (PSW) indicated that a resident had an injury that progressively worsened for days prior to being sent to the hospital. During this time the resident was provided with interventions for the injury however they continued to experience symptoms. A diagnostic test was ordered, which the home failed to ensure was completed. Days later, the resident was taken to the hospital where the test was completed, the injury was confirmed, and appropriate interventions were provided. The inaction in ensuring the test was completed impacted the resident’s well-being due to the delayed diagnosis. Staff members agreed that the length of time this taken to complete the test was unacceptable.

Inaction by staff to ensure the diagnostic test was completed for the resident caused a delay in treatment for the injury and prolonged the symptoms.

Sources: Resident’s progress notes and chart; and interviews with the DOC and RPN.

[741521]

## WRITTEN NOTIFICATION: Falls Prevention and Management

### NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls.

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In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that after a fall when there was a significant change in health status, a post fall risk assessment tool was used, and must be complied with.

**Rationale and Summary:**

A resident fell and sustained an injury that resulted in a change of health status. According to the homes policy, the use of a clinically appropriate tool was required to assess residents post fall and was to be completed within the homes electronic health record system. The DOC and RPN confirmed that this incident required staff to use a clinically appropriate tool after the fall however, staff did not follow the homes policy as the assessment tool was not completed for this resident post fall.

Failure to perform required assessments places the resident at risk for repeated injury.

Sources: Resident's assessments, and Fall Prevention and Management in Long Term Care, last revised September 2021; and interviews with the DOC and RPN.

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## WRITTEN NOTIFICATION: Skin and Wound Care

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon return from the hospital.

**Rationale and Summary:**

Upon a resident's returned to the home after being discharged from the hospital, a skin and wound assessment was not completed by staff on the same day. An RPN confirmed this resident did meet the criteria to be at risk for altered skin. Therefore, a skin assessment using the clinically appropriate tool was required for this resident but, was not completed by staff.

Failure to perform skin assessments using a clinically appropriate tool upon return from hospital may increase the risk for delayed identification of skin impairment and treatment.

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Sources: Resident's assessments, and progress notes, the home's 'Skin and Wound Care Policy-Pressure-Injuries,' last revised August 2021; and interviews with the DOC and RPN.  
[741521]

### **WRITTEN NOTIFICATION: Skin and Wound Care**

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

**Rationale and Summary:**

Two PSWs reported that a resident had a new skin injury. The resident had to be transferred to the hospital due to worsening condition of the skin injury. According to the home's policy for skin and wound care, registered staff were to assess residents for altered skin integrity by using an appropriate clinical assessment tool for residents with altered skin conditions. Staff members confirmed that a skin assessment should have been performed, but the required assessment tool was not completed.

Failure to perform skin assessments increased the risk of delayed wound healing.

Sources: Resident's clinical assessments and progress notes, the home's 'Skin and Wound Care Policy-Pressure-Injuries,' last revised August 2021; and interviews with the DOC, a PSW, and an RPN.  
[741521]

### **WRITTEN NOTIFICATION: Pain Management**

**NC #006 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 that when a resident's pain was not relieved by initial

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interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

**Rationale and Summary:**

A resident had been provided a pain intervention, however, they continued to experience pain and reported this to the staff. The home's pain management policy instructed staff to conduct a pain assessment when a resident's pain was not relieved by initial interventions. An RPN indicated the resident did experience breakthrough pain despite being provided with an intervention but was not assessed using the clinically appropriate pain tool for pain assessment. Staff members stated the resident should have been assessed using the appropriate tool for pain assessment.

Failure to assess the resident's pain, when not relieved by initial interventions, increased the risk of prolonged uncontrolled pain.

Sources: Resident's pain assessments, progress notes, and the home's 'Pain Management Program,' last revised April 2018; and interviews with the DOC and RPN.

[741521]