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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 20, 2018	2018_714673_0002	013408-17	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Altamont Care Community
92 Island Road SCARBOROUGH ON M1C 2P5

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

BABITHA SHANMUGANANDAPALA (673)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 22, 23, 25 and 26

This inspection was completed concurrently with Resident Quality Inspection #: 2018_714673_0001. During the course of the inspection, the inspector conducted record review of health records.

During the course of the inspection, the inspector(s) spoke with Residents, Substitute Decision-Maker (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Doctor of Medicine (MD), Director of Care (DOC) and Executive Director (ED)

The following Inspection Protocols were used during this inspection: Hospitalization and Change in Condition

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the Substitute Decision-Maker

(SDM), if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) by SDM #202 regarding the care received by resident #009 before they passed away. SDM #202 also voiced concerns about not being notified when resident #009's condition began to decline.

Review of resident #009's progress notes on a specified date, revealed an entry by RN #145 which stated that a family discussion took place about resident #009's declining health status and MD #146 advised SDM #202 of an identified medication that would help resident #009's future potential symptoms, but that its side effects could cause possible death. The progress note further stated that staff would inform SDM #202 if the identified medication was needed.

A subsequent progress note seven days later revealed another entry by RN #145 which stated that SDM #202 stated that staff can initiate the use of this identified medication at any time if resident #009 exhibited specified symptoms. Review of the physician's orders revealed an order written on this same day, for the identified medication to be administered as needed, for specified symptoms.

A subsequent progress note from the day that resident #009 passed away, revealed an entry by RN #130 at 1124hrs, which stated that they were informed by a family member that resident #009 was exhibiting an identified symptom. RN #130 informed the Nurse Practitioner (NP) of resident #009's status.

A progress note on the same day at 1332hrs, revealed an entry by RPN #147, which stated that staff had reported that resident #009 was exhibiting another identified symptom at 1200hrs. At 1436 hrs, RPN #147 documented that resident #009 had an identified incident with no injuries.

A progress note on the same day at 1552hrs revealed an assessment by a NP which stated that resident #009 had a change in their level of consciousness, and an identified abnormal vital sign. Another progress note on the same day at 1633hrs revealed an entry by RN #145 which stated that they were informed by an RN that SDM #202 wanted to speak with them. RN #145 stated in the progress note that they discussed resident #009's current health status and maintaining the current treatment plan with SDM #202.

In an interview, RN #145 stated that they were working as the nursing supervisor on this day, and they had communicated to SDM #202 about maintaining resident #009's plan of care including the identified medication mentioned above, but they did not inform SDM #202 about the findings of the NP assessment or the symptom exhibited by resident #009 at 1200hrs that day.

Subsequent progress note entries on the same day, revealed documentation by RPN #148 at 1633hrs, 1634hrs and 1746hrs that resident #009 was unable to take their ordered medications as they were too drowsy. At 1950hrs, RPN #148 documented that they administered the above identified medication as resident was exhibiting specified symptoms requiring the medication, with a follow up note at 2032hrs which stated that the identified medication had been effective. At 2154hrs, RPN #148 further documented that resident #009 was non-responsive when received into their care and that SDM #202 had been updated at 1445hrs. SDM #202 arrived on the unit at 1955hrs, and at 2200hrs resident #009 succumbed.

In an interview, SDM #202 stated that no one had informed them that there was a change in resident #009's health status. They stated that RPN #147 called to inform SDM #202 that resident #009 had had an identified incident without injury, and that SDM #202 called the unit again later that day and spoke with RN #145 who also stated that resident #009 was stable. SDM #202 stated that neither of the staff members or an NP mentioned that there was a change in resident #009's health status including the symptom exhibited by resident #009 at 1200hrs, or findings identified in the NP assessment. SDM #202 further stated that no one had discussed the identified medication with them on the day that resident #009 passed away, or informed them before administering the identified medication as per their request.

In an interview, PSW #149 stated that on the day that resident #009 passed away, resident #009's condition was worse than other days.

In interviews, RN #130 and RPN #147 stated that the symptom exhibited by resident #009 at 1200hrs, and the findings identified in the NP assessment on day that resident #009 passed away, are considered changes in condition for which the SDM and MD should be informed. RPN #147 further stated that on the day that resident #009 passed away, they informed SDM #202 that resident #009 had an identified incident with no injuries, but did not inform them about the symptom exhibited by resident #009 at 1200hrs, or the findings of the NP assessment. RN #130 further stated they could not remember if SDM #202 was informed of resident #009's change in condition, or why they

had not documented it.

In an interview, RN #145 stated that as per the documentation, SDM #202 had wanted to be informed prior to the administration of the identified medication when it was discussed with MD #146 on an identified date, and that seven days later, SDM #202 stated that staff can initiate the use of the identified medication at any time if resident #009 exhibits an identified symptom. When the inspector asked for clarification whether SDM #202 explicitly stated that they no longer had to be informed before the administration of the identified medication, RN #145 declined to answer and stated that they could only speak to what was documented. During a follow up interview, RN #145 stated that SDM #202 explicitly told them that if resident #009 exhibited an identified symptom, they did not have to wait to inform SDM #202 and could proceed to administer the identified medication. When asked why this wasn't documented, RN #145 stated that they document specific things but not everything.

In an interview, RPN #148 stated that findings of the NP assessment were considered a change in condition, in which case the SDM and MD should be informed. RPN #148 further stated that when they began their shift at 1500hrs the day that resident #009 passed away, resident #009 presented with a change in condition. RPN #148 stated that they did not inform SDM #202 as they assumed that RN #145 had done so as per the progress notes. RPN #148 stated that the identified medication was administered as per the MD's order. Upon reviewing the progress notes during the interview, RPN #148 stated that their understanding of the plan of care was that SDM #202 should have been informed prior to the administration of the identified medication and that they had not referred to the progress notes on the day that resident #009 passed away.

In an interview, MD #146 stated that being asked to be informed before the administration of the identified medication is not an uncommon request in these types of situations; however, MD #146 stated that they could not remember the details of SDM #202's request related to resident #009's specified medication as they had not documented this.

In an interview, DOC #126 stated that the symptom exhibited by resident #009 at 1200hrs, and the findings identified in the NP assessment are considered a change in status and that SDM #202 should have been contacted so that they could be provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

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Issued on this 26th day of February, 2018

[redacted]

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

Original report signed by the inspector.