Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Jun 20, 2018	2018_378116_0008	032631-16, 033617-16, 035039-16	Critical Incident System

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

SARAN DANIEL-DODD (116)

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 27, May 1, 2, 3, 14, 2018.

The purpose of this inspection was to inspect upon the following critical incident system (CIS) reports:
- Log #032631-16 related to staff to resident neglect,
- Log #033617-16 related to staff to resident physical abuse and theft and,
- Log #035039-16 related to staff to resident physical abuse.

The residents' health records including written plans of care, medication administration, treatment administration records, progress notes, physician's orders and external clinical records were reviewed.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Associate Director of Care (ADOC), registered staff members (RN), (RPN) and personal support workers (PSW).

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

The home submitted a Critical Incident System (CIS) report on an identified date, to the Director of the Ministry of Health and Long-Term Care (MOHLTC), related to staff to resident neglect. The CIS read as follows:

Resident #001 was transferred to the hospital on an identified date, for further assessment due to the sudden development of identified symptoms. The resident was admitted to the hospital with a specified diagnosis. An identified individual sent communication to the home's ED stating that an identified staff member at the hospital communicated that resident #003's symptoms are due to specified care not being provided to resident #003 prior to the transfer to the hospital.

Resident #003 was admitted to the home on an identified date with identified diagnoses and required treatments.

A review of the initial written plan of care under a specified focus directed staff to perform an identified task and to document and report identified signs and/or symptoms to the physician.

Interviews held with registered staff members #106, #107 and #108 indicated they were responsible to monitor resident #003 for identified signs and/or symptoms and were instructed not to perform the identified task as it was considered a specialized area to be treated by specified individuals.

A review of the resident's health record including medication administration records (MAR), treatment administration records (TAR) and progress notes were reviewed for an identified period. There was no documentation to support that a physician's order or directives pertaining to the identified task were in place.

A review of the written plan of care found that the written plan of care was not updated until the resident's return from hospital, to reflect that the role of the identified task are to be performed by specific individuals.

Interviews held with RN #106, the ADOC and the ED confirmed that the care set out in the plan of care related to the identified task was not provided to resident #003 as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 21st day of June, 2018

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

Original report signed by the inspector.