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
Jun 5, 2019	2019_486653_0013	007444-17, 008096-17, 018343-17, 024007-17, 025835-17, 027169-17, 007785-18, 024296-18, 032688-18, 002991-19	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

ROMELA VILLASPIR (653), ANGIEM KING (644), DIANE BROWN (110), LAURIE MORRISON (747)

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): May 17, 21, 22, 23, 24, 27, 28, 29, 30, and 31, 2019.

The following complaint intakes were inspected during this inspection:

Log #(s):
-018343-17, 025835-17, 027169-17, related to transfers and plan of care,
-032688-18, related to allegation of abuse,
-007785-18, related to bathing, plan of care, and significant weight changes,
-007444-17, 008096-17, 024007-17, related to continence care and transfers, meal service and safe food temperatures, and the home's complaint process,
-024296-18, related to medication administration,
-002991-19, related to significant change in condition.

During the course of the inspection, the inspector(s) conducted observations of resident care provision, staff and resident interactions, reviewed clinical health records, staff training records, staffing schedules, staff employment records, the home's complaints and Critical Incidents (CI) binder, and investigation records.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Registered Dietitian (RD), Assistant Directors of Care (ADOCs), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **3 WN(s)**
- **3 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 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 had failed to ensure that the care set out in the plan of care was provided to residents #021, #027, and #030 as specified in the plan.

The Ministry of Health and Long-Term Care (MOHLTC) received two separate complaints related to resident #021's care in the home. The concerns were related to the required staff assistance not provided to the resident for transfers and Activity of Daily Living (ADL).

A review of resident #021's written plan of care indicated they required an identified number of staff for transfers and the identified ADL.

During an interview, PSW #100 acknowledged they were assigned to resident #021's care on the identified dates and shifts, and acknowledged in both cases care had not been provided to resident #021 as specified in the plan as it related to transfers and ADL. The PSW stated they had made a mistake and was disciplined following both incidents.

During an interview, the Executive Director (ED) acknowledged awareness of the above mentioned incidents and indicated PSW #100 was disciplined and reeducated following both incidents. The ED further acknowledged care had not been provided to resident #021 as specified in the plan in both incidents. [s. 6. (7)]

2. The MOHLTC received a complaint related to resident #027 not receiving an identified care provision.

A review of resident #027's medical directives signed by the physician indicated an identified protocol to be followed under identified circumstances.

A review of resident #027's Point of Care (POC) documentation for an identified ADL,

PCC alerts and electronic Medication Administration Record (eMAR) did not identify the protocol had been followed under the identified circumstances.

During separate interviews, RN #141 and Assistant Director of Care (ADOC) #102 reviewed resident #027's POC documentation, PCC alerts, and eMAR with the inspector, and both of them acknowledged that care was not provided to the resident as specified in the plan as it related to the identified protocol. [s. 6. (7)]

3. As a result of an area of non-compliance found under s. 6 (7) related to resident #027, the sample size had been expanded to two more residents.

A review of resident #030's physician medication review signed by the physician indicated an identified protocol to be followed under identified circumstances.

A review of resident #030's POC documentation for an identified ADL, PCC alerts and eMAR did not identify the protocol had been followed under the identified circumstances.

During separate interviews, RPN #140 and ADOC #102 reviewed resident #030's POC documentation, PCC alerts, and eMAR with the inspector, and both of them acknowledged that care was not provided to the resident as specified in the plan as it related to the identified protocol. [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 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that every alleged abuse of a resident by anyone that the licensee knew of, was immediately investigated.

The MOHLTC received a complaint letter indicating an allegation of abuse of resident #028 by PSWs in the home. The complainant indicated the resident's family member reported to an identified health care professional that the resident was being abused in the home.

A review of the health care professional's consultation note indicated information in regards to allegation of staff to resident abuse, and to keep the note for ADOC #102.

A review of resident #028's physician prescriber's orders form and the physician's multidisciplinary progress note indicated resident #028 was abused as per the health care professional's report, and that the ADOC will follow-up.

An interview with ADOC #102 indicated awareness of the allegation of abuse reported by the resident's family member to the health care professional, and acknowledged they did not investigate nor document about the allegation of abuse and what they had done about it. The ADOC further indicated they should have investigated after being made aware of the allegation of abuse regarding resident #028.

During an interview, the ED and the inspector reviewed the health care professional's note, digital prescriber's orders form, and multidisciplinary progress notes. The ED indicated they were not aware of the allegation of abuse and acknowledged that based on the information presented, the allegation should not have been dismissed and it should have been investigated and followed up on. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that resident #027 was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The MOHLTC received a complaint related to resident #027 not receiving their bath/ shower.

During a telephone interview, the complainant indicated when the regular PSW was not on duty, resident #027 did not receive their bath/ shower.

A review of resident #027's POC documentation for bathing and corresponding progress notes from five different periods, indicated they did not receive their bath/ shower at a minimum of twice per week.

Separate interviews with PSWs #106 and #142 and RPN #140 indicated bath/ showers were provided to residents twice a week. In some cases, when the home was short staffed or if the resident refused, bath/ showers were not provided to the residents as scheduled.

An interview with the ADOC indicated bath/ showers were provided twice a week to each resident in the home unless requested otherwise by the resident. The ADOC stated PSWs documented on POC after they had provided the bath/ shower to the resident, and if there was no documentation found on the POC it meant the bath/ shower was not completed. The inspector and the ADOC reviewed resident #027's POC documentation for bathing from five different periods, and the ADOC acknowledged resident was not bathed, at a minimum, twice a week by the method of their choice. [s. 33. (1)]

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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 5th day of June, 2019

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

Original report signed by the inspector.