



**Ministry of Long-Term
Care**

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

**Ministère des Soins de longue
durée**

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**
**Division des opérations relatives aux
soins de longue durée**
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 13, 2020	2020_814501_0012	014657-20	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

SUSAN SEMEREDY (501)

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): October 20, 21, 22, 23, 27, 28, 29, 30, November 2, 3, 2020.

**The following intake was completed in this critical incident (CI) inspection:
Log # 014657-20 related to safe transferring.**

During the course of the inspection, the inspector observed the provision of care, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), personal support workers (PSWs) and residents.

**The following Inspection Protocols were used during this inspection:
Personal Support Services**

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)**

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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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that PSWs used safe transferring techniques when assisting a resident.

Two PSWs transferred a resident using a mechanical lift. During the transfer the resident started having responsive behaviours and sustained an injury requiring them to go to the hospital. An interview with an ADOC indicated the PSWs should not have transferred the resident when they were exhibiting responsive behaviours.

It is unsafe to transfer residents when they are having responsive behaviours as it could cause injury.

Sources: Resident's progress notes, CIS report, home's investigation notes, and interviews with an ADOC and other staff.

[s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.



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Issued on this 13th day of November, 2020

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

Original report signed by the inspector.