Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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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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_748653_0020	007677-20, 011175-20, 014099-20, 015641-20, 015651-20, 016286-20, 016288-20, 016289-20, 016290-20, 016291-20, 016292-20, 016293-20, 016294-20, 016295-20, 016296-20, 016297-20	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), SUSAN SEMEREDY (501)

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): October 20, 21, 22, 23, 26, 27, 28, 29, 30, November 2, 3, 2020.

During the course of the inspection, the following intakes were inspected:

Complaint Log #(s):
-007677-20 related to the attending physician not being on-site at the home in April 2020, sudden change in the resident's health and condition, and the SDM not being notified;
-011175-20 related to the resident's weight loss, fluid monitoring, skin and wound care, continence care, and personal support services;
-014099-20 related to environmental concerns.

Follow-Up Log #(s):
-015641-20, CO #001 issued on July 29, 2020, within report #2020_715672_0007, related to LTCHA, 2007 S.O. 2007, c.8, s. 19 (1);
-015651-20, CO #001 issued on July 29, 2020, within report #2020_715672_0006, related to O. Reg. 79/10, s. 68 (2);
-016286-20, CO #001 issued on July 29, 2020, within report #2020_595110_0009, related to LTCHA, 2007 S.O. 2007, c.8, s. 5;
-016288-20, CO #003 issued on July 29, 2020, within report #2020_595110_0009, related to O. Reg. 79/10, s. 26 (3) 14;
-016290-20, CO #004 issued on July 29, 2020, within report #2020_595110_0009, related to O. Reg. 79/10, s. 33 (1);
-016296-20, CO #005 issued on July 29, 2020, within report #2020_595110_0009, related to O. Reg. 79/10, s. 229 (4);
-016295-20, CO #006 issued on July 29, 2020, within report #2020_595110_0009, related to O. Reg. 79/10, s. 73 (1) 5;
-016291-20, CO #007 issued on July 29, 2020, within report #2020_595110_0009, related to O. Reg. 79/10, s. 50 (2) d;
-016289-20, CO #008 issued on July 29, 2020, within report #2020_595110_0009, related to O. Reg. 79/10, s. 26 (4);
-016297-20, CO #009 issued on July 29, 2020, within report #2020_595110_0009, related to O. Reg. 79/10, s. 71 (4);
-016292-20, CO #010 issued on July 29, 2020, within report #2020_595110_0009, related to O. Reg. 79/10, s. 73 (1) 6;
-016293-20, CO #011 issued on July 29, 2020, within report #2020_595110_0009, related to O. Reg. 79/10, s. 73 (1) 9 and s. 73 (1) 10;

-016294-20, CO #012 issued on July 29, 2020, within report #2020_595110_0009, related to O. Reg. 79/10, s. 73 (2).

During the course of the inspection, the inspector(s) toured the home, observed the residents, provision of care, meal services, snack pass, Infection Prevention and Control (IPAC) practices, reviewed clinical health records, hospital records, staff training records, staffing plan, supporting documentations related to the compliance orders, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Scheduler, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Infection Prevention and Control (IPAC) Lead, Resident Assessment Instrument (RAI) Coordinator, Dietary Aides (DAs), Food Service Supervisor (FSS), Registered Dietitian (RD), Director of Dietary Services (DDS), Physiotherapist (PT), Funeral Director (FD), Toronto Public Health (TPH), Housekeepers (HKs), Environmental Services Manager (ESM), Resident Relations Coordinator (RRS), Social Worker (SW), Assistant Directors of Care (ADOCs), Director of Care (DOC), and the Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

- **5 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_715672_0007	653
O.Reg 79/10 s. 229. (4)	CO #005	2020_595110_0009	653
O.Reg 79/10 s. 26. (3)	CO #003	2020_595110_0009	501
O.Reg 79/10 s. 26. (4)	CO #008	2020_595110_0009	501
O.Reg 79/10 s. 33. (1)	CO #004	2020_595110_0009	501

LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2020_595110_0009	653
O.Reg 79/10 s. 50. (2)	CO #007	2020_595110_0009	653
O.Reg 79/10 s. 68. (2)	CO #001	2020_715672_0006	501
O.Reg 79/10 s. 71. (4)	CO #009	2020_595110_0009	501
O.Reg 79/10 s. 73. (1)	CO #010	2020_595110_0009	501
O.Reg 79/10 s. 73. (1)	CO #011	2020_595110_0009	501
O.Reg 79/10 s. 73. (1)	CO #006	2020_595110_0009	501
O.Reg 79/10 s. 73. (2)	CO #012	2020_595110_0009	501

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. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, when they had a change of more than 5 per cent of body weight over one month.

A review of a resident’s weight summary records indicated they lost more than 2 Kilograms (KG) between December 2019, and January 2020. A review of progress notes indicated the Registered Dietitian (RD) assessed the resident for the weight loss, and noted possible weight measurement error thus, no new approaches were implemented in response to the weight loss.

Separate interviews with the Personal Support Worker (PSW) #122 and Registered Practical Nurse (RPN) #121 indicated they recall the resident's noticeable weight loss, and it was related to the resident's refusal to eat. The RPN further stated the resident was referred to the RD. During an interview, the RD reviewed the weight summary records, and indicated it was more than 5 per cent change of body weight over one month. The RD stated at that time, they were not sure whether the January weight was accurate, but acknowledged that a re-weigh was not done to confirm the weight. The RD further indicated after the February 2020 weight was taken, when the resident further lost weight, that was when they realized there could have been a real weight loss between December 2019, and January 2020. The RD further stated they would normally involve the Nurse Practitioner (NP) with significant weight changes, however, they could not recall doing so in this situation. The RD could not demonstrate that the resident was assessed using an interdisciplinary approach, and that actions were taken, and outcomes were evaluated when the resident had a change of more than 5 per cent of body weight over one month. The RD acknowledged there was a delay in dietary interventions, which put the resident at risk for malnutrition.

Sources: Resident's weight summary records, progress notes; interviews with PSW #122, RPN #121, and the RD. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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 written plan of care sets out the planned care for residents #062, #001, and #008.

A review of resident #062's clinical health records indicated their diet order for food and fluid textures. The resident was also noted to have an alteration in skin integrity. Resident #062's written plan of care indicated the resident was not able to feed themselves and was at nutritional risk due to dietary issues and skin impairments. The plan failed to identify the resident's hydration status and their hydration risks.

An interview with the RD confirmed there was no identification of a resident's hydration status or risks to hydration on the resident's written plan of care. The RD stated that they received direction from their corporate office to only include hydration status and risks to hydration as a focus in the plan of care when the resident was not meeting their fluid goals and an intervention was added. Further interview with the RD indicated resident #062 started refusing food and fluids, and their assessment indicated the resident was not meeting their fluid goals. Progress notes revealed a trial of a treatment. A review of the resident's plan of care following the initiation of the treatment, did not identify the resident's hydration status and their hydration risks.

In separate interviews with the RD and the Director of Care (DOC), each indicated resident #062 was at risk for dehydration due to increased fluid requirement for wound healing, reduced accessibility of free fluids, and requiring assistance from staff for feeding.

Sources: Resident #062's clinical health records including progress notes, physician orders, and care plans; Interviews with the RD and the DOC. [s. 6. (1) (a)]

2. Resident #001's current written plan of care indicated they were at nutritional risk due to significant weight loss, low intake, skin issues, and dietary issues. Physician orders indicated the resident had an alteration in skin integrity. An interview with the RD indicated resident #001 was at risk for dehydration due to increased fluid requirement for wound healing. The RD confirmed that the hydration status and risks to a resident's status were not identified in a resident's written plan of care which has not been the practice in the home.

Sources: Resident #001's clinical health records including physician orders, and current plan of care; Interview with the RD. [s. 6. (1) (a)]

3. Resident #008's current written plan of care indicated they were at nutritional risk due to their disease diagnosis and alteration in skin integrity. An interview with the RD indicated resident #008 was at risk for dehydration due to increased fluid requirement related to their disease diagnosis and wound healing. The RD confirmed that the hydration status and risks to a resident's status were not identified in a resident's written plan of care which has not been the practice in the home.

Not having a hydration focus in the written plan of care puts residents at risk by not

identifying their specific hydration needs and the basis for these needs.

Sources: Resident #008's clinical health records including progress notes, and current plan of care; Interview with the RD. [s. 6. (1) (a)]

4.The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to resident #001.

A review of the resident's care plan, kardex, and support actions, did not identify information regarding their use of dentures. During the course of the inspection, Inspector #653 observed the resident was having their meal without their dentures put on, and in another observation, the resident had their dentures on overnight.

An interview with PSW #111 indicated there was no information on resident #001's care plan regarding their denture care. The PSW stated the resident had a preference regarding their denture care.

During an interview, the DOC stated the use of dentures would not be noted on the plan of care if there were no issues. However, the DOC acknowledged, as the inspector had identified, it was an issue and further indicated that the use of dentures should be in the resident's plan of care.

Sources: Inspector #653's observations; Resident #001's care plan, kardex, and support actions; Interviews with PSWs #111 and #113 and the DOC. [s. 6. (1) (c)]

5. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #004, collaborated with each other in the assessment of the resident, so that their assessments were integrated, and were consistent with, and complemented each other.

A review of resident #004's progress notes indicated they were sent to hospital on a day in April 2020, as they had a change in their health condition. A review of resident #004's meal intake records from a time period in April 2020, indicated they refused to eat breakfast, lunch, and dinner on two dates, and had poor meal intake on five dates.

Separate interviews with PSW #134, RPNs #110 and #129 indicated poor food intake was within the resident's normal baseline, thus, they were receiving a nutritional supplement. Both RPNs indicated the resident drank more than they ate their meals, and

RPN #129 stated they do not recall sending a referral to the RD related to poor food intake, prior to the resident's hospitalization.

During an interview, the RD reviewed resident #004's meal intake records, and indicated they would have expected a referral from the registered staff based on the poor meal intake. The RD reviewed progress notes and referrals, and acknowledged no referral was made. During an interview, the DOC stated the risk associated to not referring a resident who had poor meal intake to the RD, was malnutrition and becoming more unwell, which would open them up for potential infection and other health issues.

Sources: Resident #004's progress notes, meal intake look back report; Interviews with PSW #134, RPNs #110, #129, RD, and the DOC. [s. 6. (4) (a)]

6. The licensee has failed to ensure that the Substitute Decision-Makers (SDMs) were provided an opportunity to participate fully in the development and implementation of the plan of care, when residents #001 and #006 experienced weight loss.

A review of resident #001's weight summary records indicated they had a significant weight loss between December 2019, and January 2020. An interview with the resident's SDM indicated they obtained the resident's health records, and noted the above mentioned significant weight loss was never reported to them. During an interview, the RD could not recall if resident #001's SDM was notified of the weight loss noted in January 2020.

Sources: Resident #001's weight summary records, progress notes; Interviews with the SDM and the RD. [s. 6. (5)]

7. A review of resident #006's weight summary records indicated they experienced weight loss between September 2020, and October 2020. An interview with the RD acknowledged that the resident's weight change was considered a significant weight loss. A review of progress notes and an interview with RN #120 indicated they do not recall informing the SDM regarding resident #006's significant weight loss.

Sources: Resident #006's weight summary records, progress notes; Interviews with the RN and RD. [s. 6. (5)]

8. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A review of resident #001's care plan indicated that staff were to ensure call bell was within their reach at all times. During the course of the inspection, Inspector #653 observed twice wherein the resident was in their bedroom, and the call was not within their reach. Separate interviews with PSWs #111 and #113 acknowledged the inspector's observations, and indicated that the call bell was supposed to be placed beside the resident, within their reach.

Sources: Resident #001's care plan; Inspector #653's observations; Interviews with PSWs #111 and #113. [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
-there is a written plan of care for each resident that sets out the planned care for the resident and clear directions to staff and others who provide direct care to the resident;
-the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;
-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;
-care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Monitoring of Resident Weights policy was complied with by staff, for residents #001, #005, and #006.

O. Reg. 79/10, s. 68 (2) (e) (i) requires that the program includes a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter. Specifically, staff did not comply with the home's "Monitoring of Resident Weights" policy revised in April 2019. The policy directed the Personal Support Workers (PSWs) to immediately reweigh any resident with a weight variance (from previous month) of 2 Kilograms (KG). The policy directed the nurse to ensure that the PSWs reweigh the resident if there was a weight change (loss or gain) of 2 KG difference in resident's weight from the previous month.

A review of resident #001's weight summary records indicated they had a weight change greater than 2 KG between December 2019 and January 2020.

During an interview, the RD reviewed the resident's weight summary records, and confirmed that the home's policy was not complied with, when the resident was not reweighed, when they had a weight change greater than 2 KG from previous month.

Sources: "Monitoring of Resident Weights" policy revised in April 2019; Resident #001's weight summary records, progress notes; Interview with the RD. [s. 8. (1) (b)]

2. A review of resident #005's weight summary records indicated they had a weight change greater than 2 KG between September 2020 and October 2020.

During an interview, the RD reviewed the resident's weight summary records, and

confirmed that the home's policy was not complied with, when the resident was not reweighed, when they had a weight change greater than 2 KG from previous month.

Sources: "Monitoring of Resident Weights" policy revised in April 2019; Resident #005's weight summary records, progress notes; Interview with the RD. [s. 8. (1) (b)]

3. A review of resident #006's weight summary records indicated they had a weight change greater than 2 KG between September 2020 and October 2020.

During an interview, the RD reviewed the resident's weight summary records, and confirmed that the home's policy was not complied with, when the resident was not reweighed, when they had a weight change greater than 2 KG from previous month.

Separate interviews with the staff indicated the following:
-PSW #111 indicated it was the registered staff who would direct the PSWs to complete a reweigh.
-RPN #121 indicated a reweigh would be completed when there was at least a 5 KG weight change from previous month.
-RN #120 indicated it was under the discretion of the RD and the Assistant Director of Care (ADOC), on when to complete a reweigh.
-ADOC #124 indicated if there was a weight change of a couple of KG, then a reweigh would be completed.
-The RD indicated a reweigh would be completed when there was a weight change of 2 KG either gain or loss, from the previous month.

The RD further indicated that the risk associated to not reweighing residents and obtaining an accurate weight, would be a potential for an on-going issue such as real weight loss, to not be identified in a timely manner, resulting in delay in assessment, treatment, and interventions by the RD.

Sources: "Monitoring of Resident Weights" policy revised in April 2019; Resident #006's weight summary records, progress notes; Interviews with PSW #111, RPN #121, RN #120, ADOC #124, and the RD. [s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care. O. Reg. 79/10, s. 34 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received assistance to insert their dentures prior to meals.

On a day in October 2020, Inspector #653 observed resident #001 had their meal in front of them, drinking their fluids, and barely touched the food. The resident did not have their dentures on, and stated that they normally ate with their dentures on, and asked the inspector if they could assist with putting them on. PSW #113 was called to the room and notified of the resident's request. An interview with the DOC indicated they would expect that if the resident required dentures in order to eat, and it was in good working order, that their dentures would be cleaned, set up, and ready prior to their meal. The DOC further acknowledged that the resident would be at risk for choking, if the dentures were not applied prior to eating their meal.

Sources: Inspector #653's observation; interviews with resident #001, PSW #113, and the DOC. [s. 34. (2)]

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 receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a designated staff member to co-ordinate the infection prevention and control program with education in infection prevention and control practices including infectious disease, cleaning disinfection, data collection and trend analysis, reporting protocols, and outbreak management.

During an interview, the inspector requested the Infection Prevention and Control (IPAC) Lead to provide records of their education on infection prevention and control practices including infectious disease, cleaning disinfection, data collection and trend analysis, reporting protocols, and outbreak management, however, the IPAC Lead was unable to provide supporting documentation of their education and confirmed they had not received education.

Sources: Interviews with the IPAC Lead, DOC, and the Executive Director (ED). [s. 229. (3)]

2. The licensee has failed to ensure that the staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

During a tour of the home, Inspector #653 noted several rooms had additional precautions signage posted on their doors. A review of home area A and B's October 2020, infection control surveillance records only identified two residents on the list, one with Urinary Tract Infection (UTI), and another one on antibiotic for redness at wound site/ bony prominence. A review of clinical health records identified residents #002, #003, #008, #016, and #017, exhibited symptoms requiring additional precautions, in the month of October.

During separate interviews, the IPAC Lead and the DOC indicated it was the responsibility of the registered staff to fill out the infection control surveillance records, for any residents presenting with signs and symptoms that the staff may be concerned about, and it does not necessarily need to be confirmed infections. The IPAC Lead indicated that the risk associated to not filling out the infection control surveillance records would be to miss potential clusters of infection or delay in identification of infection.

Sources: Inspector #653's observation; Residents' progress notes; Interviews with the IPAC Lead and the DOC. [s. 229. (5) (a)]

3. The licensee has failed to ensure that the staff on every shift recorded symptoms of infection in residents and had taken immediate action as required.

During an observation, Inspector #653 noted that a room in wing two had contact

precautions signage on the door, and RPN #112 confirmed it was for resident #003. A review of the resident's progress notes and digital prescriber's orders form indicated they exhibited signs and symptoms. During an interview, the IPAC Lead indicated that the required additional precautions for resident #003's symptoms, were droplet and contact precautions. The risk associated to not putting in place the appropriate additional precautions, would be possible transmission of infectious agents.

Sources: Inspector #653's observations; Resident #003's progress notes, digital prescriber's order form; Interviews with RPN #112 and the IPAC Lead. [s. 229. (5) (b)]

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:
-to designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including, (a) infectious diseases; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management;
-that on every shift, (a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
-that on every shift, (b) the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

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.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROMELA VILLASPIR (653), SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2020_748653_0020
Log No. / No de registre :	007677-20, 011175-20, 014099-20, 015641-20, 015651-20, 016286-20, 016288-20, 016289-20, 016290-20, 016291-20, 016292-20, 016293-20, 016294-20, 016295-20, 016296-20, 016297-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 13, 2020
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Altamont Care Community 92 Island Road, SCARBOROUGH, ON, M1C-2P5
	Jane Smith

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Name of Administrator / Nom de l’administratrice ou de l’administrateur :

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee must be compliant with s. 69 of O. Reg. 79/10.

Specifically, the licensee must:

1. Develop and implement a process to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
-1. A change of 5 per cent of body weight, or more, over one month.
-2. A change of 7.5 per cent of body weight, or more, over three months.
-3. A change of 10 per cent of body weight, or more, over 6 months.
-4. Any other weight change that compromises the resident's health status.

2. A record is required to be kept by the licensee for all actions undertaken in item #1. The record shall be made available to the inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated, when they had a change of more than 5 per cent of body weight over one month.

A review of a resident's weight summary records indicated they lost more than 2 Kilograms (KG) between December 2019, and January 2020. A review of progress notes indicated the Registered Dietitian (RD) assessed the resident for the weight loss, and noted possible weight measurement error thus, no new approaches were implemented in response to the weight loss.

Separate interviews with the Personal Support Worker (PSW) #122 and Registered Practical Nurse (RPN) #121 indicated they recall the resident's noticeable weight loss, and it was related to the resident's refusal to eat. The RPN further stated the resident was referred to the RD. During an interview, the RD reviewed the weight summary records, and indicated it was more than 5 per cent change of body weight over one month. The RD stated at that time, they were not sure whether the January weight was accurate, but acknowledged that a re-weigh was not done to confirm the weight. The RD further indicated after the February 2020 weight was taken, when the resident further lost weight, that was when they realized there could have been a real weight loss between December 2019, and January 2020. The RD further stated they would normally involve the Nurse Practitioner (NP) with significant weight changes, however, they could not recall doing so in this situation. The RD could not demonstrate that the resident was assessed using an interdisciplinary approach, and that actions were taken, and outcomes were evaluated when the resident had a change of more than 5 per cent of body weight over one month. The RD acknowledged there was a delay in dietary interventions, which put the resident at risk for malnutrition.

Sources: Resident's weight summary records, progress notes; interviews with PSW #122, RPN #121, and the RD.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the resident because they were not assessed using an interdisciplinary approach, and actions were not taken to address the weight loss when their January 2020, weight was not confirmed by way of a reweigh, and they experienced further weight loss in the following month and was at risk for malnutrition.

Scope: The scope of this non-compliance was isolated as one of the three residents reviewed during the inspection, was not assessed using an interdisciplinary approach, and actions were not taken, and outcomes were not evaluated when there was a change of more than 5 per cent of body weight over one month.

Compliance History: Multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation in the past 36 months. (653)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Romela Villaspir

Service Area Office /
Bureau régional de services : Central East Service Area Office