Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: September 15, 2023

Inspection Number: 2023-1012-0004

Inspection Type:
Critical Incident
Follow up

Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.

Long Term Care Home and City: Altamont Care Community, Scarborough

Lead Inspector	**Inspector Digital Signature**
Sheri Williams (741748)	Sheri A Williams Digitally signed by Sheri A Williams Date: 2023.10.06 10:22:57 -04'00'

Additional Inspector(s)
Rita Lajoie (741754)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 23 - 25, and 28 - 31, 2023
The following intake(s) were inspected:

- Intake: #00085513-Follow-up #: 1 -Compliance Order (CO) #001/2023_1012_0002 - FLTCA, 2021 - s. 6 (10) (b),), Compliance Due Date (CDD) July 1, 2023.
- Intake: #00085512-Follow-up #: 1 -CO #002/2023_1012_0002 -O. Reg. 246/22 - s. 55 (2) (b) (iv), CDD July 1, 2023
- Intake: #00085514- Follow-up #: 1 -CO #003/2023_1012_0002 - O. Reg. 246/22 - s. 57 (2), CDD July 1, 2023
- A Critical Incident related to a fall of resident resulting in transfer to hospital
- A Critical Incident related to improper care of resident by staff

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1012-0002 related to FLTCA, 2021, s. 6 (10) (b) inspected by Rita Lajoie #741754
Order #002 from Inspection #2023-1012-0002 related to O. Reg. 246/22, s. 55 (2) (b) (iv) inspected by Sheri Williams #741748
Order #003 from Inspection #2023-1012-0002 related to O. Reg. 246/22, s. 57 (2) inspected by Rita Lajoie (#741754)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident's plan of care was followed in relation to falls prevention interventions.

Rationale and Summary

A Critical Incident report (CIR) was submitted to the Director for an incident that caused an injury to a resident for which the resident was sent to hospital and resulted in a significant change in the resident's health status.

A resident was observed on video surveillance ambulating without an assistive device. At the time of the

incident the resident was assigned one on one monitoring by staff. The staff member who was assigned to provide one on one supervision was visible intermittently in the video surveillance but at no time were they observed offering the resident their assistive device. The fall occurred in the resident's room after they were escorted back to the room by staff.

Staff stated that they did not review the resident's plan of care. Staff confirmed that they were aware that the resident was at high risk for falls and that they were to use an assistive device at all times.

Falls interventions were documented in the plan of care indicating that the resident must utilize an assistive device at all times when ambulating and they were at high risk of falls related to their medical condition.

Failing to ensure that the resident's plan of care regarding ambulation was followed contributed to the outcome of injury sustained by the resident.

Sources: CIR, resident records, interviews with staff and video surveillance.
[741754]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) b

The licensee failed to ensure interventions were in place to respond to a resident's responsive behaviours.

Rationale and Summary

A CIR was submitted to the Director for an allegation of incompetent care/treatment of a resident.

The plan of care for a resident documented interventions for responsive behaviour which included one to one supervision for safety, and that staff were to explain a procedure to the resident and give them time to process.

A video review of the incident showed a resident entering the nursing station without one to one supervision. Video observation of the incident showed the resident demonstrating responsive behaviours. Staff put the resident's hands behind their back while walking them back to their room.

Staff stated that as they let go of the resident's hands, the resident had responsive behaviours and fell resulting in an injury for which they were transferred to the hospital. Staff stated that staff should have let the resident settle down and reapproach them later.

Staff stated they were not providing one on one supervision when the resident entered the nursing station. The Behaviour Supports Ontario (BSO) Lead stated that staff should have been supervising the resident and reported their responsive behaviours to the Charge Nurse.

Failure to implement interventions to respond to a resident's responsive behaviours resulted in actual harm to the resident when they suffered an injury and had to be transferred to hospital.

Sources: CIR, Responsive Behaviour Management Policy, clinical records, plan of care, surveillance video, one on one staffing guidelines, interviews with BSO Lead and staff.
[741748]

WRITTEN NOTIFICATION: BEHAVIOURS AND ALTERCATIONS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee has failed to ensure procedures and interventions were implemented to assist residents and staff who were at risk of harm as a result of a resident's responsive behaviours.

Rationale and Summary

A CIR was submitted to the Director related to a fall with injury incident as a result of a resident's responsive behaviours. A resident was demonstrating responsive behaviours and fell, resulting in injuries for which they were transferred to hospital.

The homes' Code White policy directs if confronted by a violent or aggressive person staff is to announce or have someone else announce "Code White and location" if the situation escalates into a dangerous situation.

In interview, the BSO Lead stated the resident's responsive behaviours were considered aggressive and a Code White should have been called. Staff walked the resident with their hands behind their back to remove them from the nursing station and back to their room. When the staff let go of the resident's

hands they had responsive behaviours and fell which resulted in an injury.

Failing to follow the procedure of calling a Code White put staff and other residents at risk of harm.

Sources: CIR, Code White-Physical Threat/Violence Policy, home's investigative notes, interviews with BSO Lead and staff.
[741748]