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 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 # / Registre no	Type of Inspection / Genre d'inspection
Jan 25, 2017	2016_377502_0017	031538-16	Resident Quality Inspection

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 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

JULIENNE NGONLOGA (502), ANGIE KING (644), JOANNE ZAHUR (589)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 2, 3, 4, 7, 8, 9, 10, 11, 14, 15, 16, 17 and 18, 2016.

The following critical incident reports intakes were concurrently inspected with the Resident Quality Inspection: #023876-15, related to fall, #006224-14, and 008731-16, related to transfer and positioning, and #005971-14, related to unexpected death.

The following complaints intakes were concurrently inspected with the Resident Quality Inspection: # 005978-14, related to accommodation service, #016483-15 related continence care and bowel management, #027546-16, and 027678-16, related to fall prevention.

During the course of the inspection, the inspector(s) spoke with the Interim Director of Administration (I-DOA), Administrative Assistant (AA), Acting Director of Resident Care (Acting DORC), Assistant Directors of Resident Care (Ass. DORC), Director of Dietary Services (DDS), Dietary Aide (DA), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activity Staff (AS), Cooks, Social Worker (SW), Facility Manager (FM), Residents, Substitute Decision Makers (SDM's), and Presidents of Residents' Council and Family Council.

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, staffing schedules, staff employment records, home's investigation record, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Resident Charges
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **6 VPC(s)**
- **1 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 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to injury in which resident#015 was transferred to hospital.

Review of resident #015's written plan of care revealed that his/her transfer status had been revised on an identified date to include the need for a two person sit-to-stand mechanical lift for all transfers.

Review of the home's investigation notes revealed that staff #108 had admitted to manually transferring resident #015 unassisted on the day of the above incident.

Observations conducted by the inspector throughout the Resident Quality Inspection (RQI) revealed that resident #015 was in bed.

In an interview, staff #108 stated that on the day of incident, resident #015 had refused to be transferred with the mechanical lift. As a result, staff #108 manually transferred resident #015 unassisted. During the transfer, a specified resident's body part buckled and staff #108 called for assistance. A second PSW assisted in seating resident #015. Staff #108 further stated that he/she should have requested the assistance of a second PSW for the above mentioned transfer.

In an interview, staff #133 stated that he/she assessed resident #015 after the incident and noted an injury. Staff #133 and # 132 stated that the transfer logo above resident #015's bed indicated the use of a sit-to-stand mechanical lift for all transfers. Staff #132 further stated the resident had required this mode of transfer for a specified health condition.

In an interview, staff #147 confirmed that staff #108 had not used safe transferring techniques with resident #015 which resulted in an injury. [s. 36.]

2. A CIS report was submitted to the MOHLTC related to a fall in which resident #008 sustained an injury causing a significant change in his/her condition on the same day. The CIS further revealed that the fall occurred during an identified care using a specified device. Review of an identified documentation for resident #008 revealed that the cause of death was complications related to the injury five months prior.

Review of the home's investigation notes revealed the following:
- Staff #137 had operated the identified device unassisted after resident #008 received an identified care,
- Staff #137 had not applied a specified safety device,
- Staff #137 revealed he/she had turned his/her back to remove the gloves and resident

#008 fell,
- Staff #137 stated the specified safety device had not been working properly for some time,
- Staff #137 stated that he/she had not been provided training on how to use the specified equipment. Although staff #137's personnel file revealed that he/she had received the training and certified as transfer coach training.
- Staff #137 has been terminated as a result of the above mentioned incident.

A review of the home's preventative maintenance reports, three months prior to the incident, for the specified device revealed no areas of disrepair had been noted.

The inspector was unable to conduct an interview with staff #137 as his/her contact information, obtained from his/her personnel file, was no longer in service.

Review of the written plan of care completed on admission, revealed that resident #008 required total level of assistance with a specified care and was to be assessed prior to the activity, related to an identified medical condition. Review of Minimum Data Set-Resident Assessment Indicator (MDS-RAI) revealed resident #008 was not able to attempt sitting without physical help.

Review of a specified training record highlights for the equipment revealed the following on pages three and four:
-that a resident must be able to maintain a Dynamic Sitting Balance in an unsupported, upright seated position,
-resident must have the ability to correct their upright seated posture without assistance,
-never leave a resident unattended (do not turn your back on the resident), and
-always maintain eye contact and/or control of the resident and their actions at all times.

In an interview, representative (AHR) #165 stated that the specified device is to be used with residents that are able to maintain trunk control. AHR #165 further stated based on resident #008's assessment, his/her should not have been provided care in the specified device,.

In an interview, staff #132 stated that resident #008's medical condition did not allow him/her to be placed in the specified equipment.

In an interview, staff #154 stated that resident #008 had been provided an identified care since admission in the home due to his/her medical condition. Staff #154 further stated

that the incident day was the first time that resident #008's care was changed.

In interviews, staff #142, #154 and #114 stated there had not been any reported issues with the specified safety equipment prior to the incident.

In an interview, staff #147 stated that two staff are required to be present when the identified equipment is used. Staff #147 also stated that the home's investigation notes related to the incident had been accurate, as the inspector was not able to verify the content with staff #137, who was terminated.

In an interview, staff #147 confirmed staff #137 had not used safe transferring techniques when assisting resident #008.

The scope of this finding is isolated to two residents; the severity is actual harm / risk. The previous compliance history revealed previous non-compliances (unrelated). As a result of this non-compliance with O. Reg. 79/10, s. 36, a compliance order is warranted. [s. 36.]

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

Resident #007 was triggered from Stage one for Potential side rail restraint.

On multiple occasions throughout the RQI, the inspector observed resident #007 in bed

and one quarter bed side rail on each side of the bed was engaged at the centre of bed.

Review of the MDS-RAI assessment revealed resident #007 was bedfast all or most of time with daily use of bed rails. Review of resident #007's written plan of care failed to reveal the use of bed side rails.

In interviews, staff #123 and #129 stated resident #007 used the bed side rails for safety and bed mobility, and then confirmed that the need for bed rails were not included in the resident's written plan of care.

In interviews, staff #124, #105, #109 and #125 confirmed that the bed rails were not included in the resident's written plan of care, and stated that the use of bed side rails by any resident should be included in the written plan of care for the staff to reference for resident care needs. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of resident #008 and his/her needs.

A CIS report was submitted to the MOHLTC related to a fall in which resident #008 sustained an injury causing a significant change in his/her condition on the same day. The CIS further revealed that the fall occurred during an identified care using a specified device. Review of an identified documentation for resident #008 revealed that the cause of death was complications related to the injury five months prior.

Review of the written plan of care completed on admission, revealed that resident #008 required total level of assistance with a specified care and was to be assessed prior to the care activity, due to an identified medical condition. Review of Minimum Data Set-Resident Assessment Indicator (MDS-RAI) revealed resident #008 was not able to attempt sitting without physical help.

In an interview, staff #132 stated that resident #008 was assessed on admission and his/her medical condition did not allow him/her to be placed in the specified device.

In an interview, staff #154 stated that resident #008 had been provided a specific care activity since admission in the home due to his/her medical condition. Staff #154 further stated that the incident day was the first time that resident #008 care was changed.

In an interview, staff #138 confirmed that the care set out in the plan of care had not been

based on resident #008’s admission assessment and his/her identified needs. [s. 6. (2)]

3. 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.

A CIS report was submitted to the MOHLTC related to injury in which resident #015 was transferred to hospital on the same day.

Review of resident #015’s most recent written plan of care revealed that the resident transfer's status had been revised on an identified day, to include the need for two person assistance.

Throughout the Resident Quality Inspection (RQI) the inspector observed resident #015 in bed.

In an interview, staff #108 stated that on the day of incident, resident #015 had refused to be transferred with the mechanical lift. As a result, staff #108 manually transferred resident #015 unassisted. During the transfer, a specified resident's body part buckled and staff #108 called for assistance. A second staff member assisted in seating resident #015. Staff #108 further stated that he/she should have requested the assistance of a second staff member for the above mentioned transfer.

In interviews, staff #107 and #133 stated that resident had required a mechanical lift for all transfers for quite some time related to medical condition. Staff #107 and #133 further stated that the transfer logo above resident #015's bed indicated the use of a sit-to-stand mechanical lift for transfers.

In an interview, staff #147 confirmed that the care set out in the plan of care had not been provided to resident #015 as specified in the plan. [s. 6. (7)]

4. On an identified date, the inspector observed resident #003 during meal service. Resident #003 was being assisted with feeding by staff #105. The resident was observed coughing while eating.

Review of resident #003's most recent written plan of care and Meal Selection Tool revealed the resident had an identified medical condition, staff are directed to thicken an identified food texture in order to prevent a symptom of the identified medical condition.

In an interview, staff #105 confirmed that he/she had not follow the above intervention, as he/she was not aware of the intervention.

In an interview, staff #120 confirmed that staff had not followed resident #003's plan of care, as staff failed to provide the specified food texture to reduce the risk to an identified medical condition. [s. 6. (7)]

5. On an identified date, the inspector observed resident #048 during meal service. The resident was served identified foods. Resident was was not provided with a protein item.

Review of resident #048’s written plan of care revealed that the resident had a specified diet. Further review of the written plan of care revealed on an identified date, staff were directed to provide a specified food daily at a specified meal for the resident’s protein needs.

In an interview, staff #164 confirmed that the resident had not been offered the identified food.

In an interview, staff #120 stated that staff did not provide care set in the plan of care as they failed to offer the identified food to the resident. Staff #120 further stated resident #048 had not met his/her nutrient intake requirement as protein was missing from the resident's meal.

In an interview, staff #101 stated that resident #048 should have been served as per resident’s plan of care. [s. 6. (7)]

6. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident # 015 was triggered from Stage I for Bed fast.

On three consecutive specified days, the inspector observed resident #015 being bed fast. Further observations of resident #015's bedside area revealed a note above the resident’s bed that directed staff to get the resident up every day except on two specified days of the week.

Record review of the most recent written plan of care revealed that resident #015 was to

be transferred out of the bed every day except on two specified days of the week .

In interviews, staff #117, #108 and #107 stated that resident had not been getting up and had remained bed fast for nearly a year. Staff #117 further stated that resident #015 had been afraid to get up related to an ongoing specified medical condition. Staff #117 also stated that the resident had been bed fast since returning from the hospital approximately a year prior to this inspection.

In an interview, staff #116 confirmed that the plan of care had not been revised when resident #015's care needs had changed. [s. 6. (10) (b)]

7. On an identified date during breakfast service, the inspector observed resident #046 eating a specific food item.

Review of the Meal Selection Tool and resident #046's most recent written plan of care revealed the resident disliked this specified food.

In an interview, staff #164 stated resident #046 had been eating this specified food every morning for the past few months.

In an interview, staff #101 stated that during resident #046's admission assessment , resident #046 told him/her that he/she dislikes this specified food. In an interview, staff #120 stated that when he/she assessed the resident on a specified date, the resident listed the foods he/she dislikes including this specified food, as well as the foods she likes. Staff #101 and staff #120 stated the resident had been reassessed quarterly after the admission assessment and confirmed that resident #046's written plan of care and Meal Selection Tool had not been revised as they were not made aware that resident #046's food preference had changed. [s. 6. (10) (b)]

8. The licensee has failed to ensure that if the plan of care was being revised because care set out in the plan has not been effective, different approaches were considered in the revision of the plan of care.

On a specified date, MOHLTC Action-Line received a complaint related to the fall prevention program in the home. The complainant stated that he/she was concerned about the increase of falls that resident #023 had been having in the home.

Review of the resident's progress notes and post fall assessment records revealed

resident #023 had fallen on 9 separate incidents within approximately four months.

Review of resident #023’s plan of care within the above mentioned period of time revealed that the resident had been assessed as being at high risk of falls. On a specified date, he/she fell out of a specified chair . Resident #023 was assessed and nursing staff documented that he/she sustained injuries. Further review revealed that staff were given specific directions related to the wheelchair to reduce the risk of falls, relieve pressure and provide comfort. After each of the falls on five specified dates, resident #023 had been reassessed and the plan of care had been reviewed to include bed to be in the lowest position.

Further review of the resident’s progress notes and written plan of care revealed on a specified date, resident #023 fell out of his/her chair and landed on the foot rest without injury; on three specified dates, resident #023 slid out of the bed, hitting his/her head lightly on the ground, and landed in a lying position at bedside without injury. After each fall resident was reassessed but record review of the written plan of care failed to review different approaches to reduce the risk of falls.

In interviews, staff #105, #156 staff #160 confirmed that other interventions had not been considered when resident was reassessed. They further stated that other interventions to consider were bed alarm, chair, alarm, floor mat for any resident at high risk of fall.

Interview with staff #125 who is also the lead of the Falls program confirmed that the home expectation is to consider different approaches to reduce the risk of falling. [s. 6. (11) (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:
- there is a written plan of care for each resident that sets out the planned care for the resident,
- the care set out in the plan of care is based on an assessment of the resident and his/her needs,
- the care set out in the plan of care is provided to the resident as specified in the plan,
- the resident was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan was no longer necessary,
- if the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were monitored during meals, including residents eating in locations other than dining areas.

On identified dates, the inspector observed resident #015 sitting in his/her bed without supervision and a meal tray placed in front of him/her. The observations also revealed that the privacy curtain had been fully drawn and resident #015 was not visible to any staff.

Review of the home's policy titled, Dining-Tray Service, policy number VII-I-10.60, and revised September 2016, revealed under the PSW responsibility point number four; residents are to be monitored when eating in their rooms and provided assistance as indicated in the kardex/care plan or as per direction given by the registered staff.

Review of the most recent written plan of care for resident #015 revealed under the nutrition focus that resident #015 was at high nutritional risk.

In an interview staff #117 stated that on an identified date, he/she had placed resident #015's identified food in a handled mug so the resident could drink it and then left him/her alone to go in the kitchen. Staff #117 further stated he/she was aware that resident was

not to be left unsupervised with meals.

In an interview, Staff #108 stated that on identified date, he/she had left resident #015 unsupervised with his/her meal as he/she had to quickly use the bathroom located in the basement. Staff #108 further stated that he/she had not informed any of his/her peers that he/she was leaving the floor and was aware that resident #015 was not to be left unsupervised.

In an interview staff #120 stated that resident was at high nutritional risk and should not be left unassisted with any meals.

In an interview staff #138 confirmed that staff had failed to monitor resident #015 during room tray service. [s. 73. (1) 4.]

2. The licensee had failed to ensure that residents were provided with any eating aids and assistive devices required to safely eat and drink as comfortably and independently as possible.

On identified date, the inspector observed resident #002 during an identified meal service. The resident was observed eating and drinking not from a adaptive devices.

Review of resident #002's Meal Selection Tool and written plan of care revealed the resident was visually impaired and staff were directed to provide food and beverage in specified adaptive devices.

In an interview, staff #106 confirmed not serving resident #002's meal on a adaptive devices as he/she did not refer to the Meal Selection Tool while serving resident #002.

In an interview, PSW #110 stated he/she never used the adaptive eating devices to serve resident #002, and stated not being aware that resident #002 required never used the adaptive eating devices during meals.

Staff #101 in an interview confirmed that staff should refer to the Meal Selection Tool to ensure residents are provided with appropriate eating aids and adaptive eating devices. [s. 73. (1) 9.]

3. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

On a specified date, the inspector observed resident #047 in his/her room during an identified meal service. The resident was lying in resting position at a 15 degree angle while being fed by staff #162.

Review of resident #047's most recent written plan of care revealed that the resident requires total assistance to eat related to specified medical conditions.

In an interview, staff #162 stated that he/she did not position the resident upright as resident will be too high for him/her to feed the resident. Staff #162 stated that he/she and felt more comfortable feeding the resident at approximately 15 degree angle position.

The inspector brought the concern to staff #108's attention. Staff #108 stated that the resident should be upright during feeding to reduce the risk of aspiration, and then he/she proceeded to reposition resident #047. [s. 73. (1) 10.]

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:
- residents are monitored during meals, including residents eating in locations other that dining areas,
- residents are provided with any eating aids, assistive devices required to safely eat and drink as comfortably and independently as possible
- proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the critical incident report had been amended with the outcome or current status of resident #008.

A CIS report was submitted to the MOHLTC related to a fall in which resident #008 sustained an injury causing a significant change in his/her condition on the same day. Review of an identified documentation for resident #008 revealed that the cause of death was complications related to the injury five months prior.

Review of the MOHLTC-CIS portal revealed that above mentioned critical incident report had last been amended on a specified date with the outcome of the home's investigation with resulted in termination of staff #137. A further review of the MOHLTC-CIS portal revealed that the CIS had not been amended with the subsequent death of resident #008.

In an interview, staff #138 confirmed that the CIS had not been amended with the subsequent death of resident #008. [s. 107. (4) 3.]

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 critical incident report had been amended with the outcome or current status of the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes, (a) hand hygiene; (b) modes of infection transmission; (c) cleaning and disinfection practices; and (d) use of personal protective equipment has been completed.

During stage one of the RQI non-compliances related to O. Reg. 79/10, s. 229 (4) were noted and as a result, the home's staff training records related to infection prevention and control were reviewed.

Review of the 2015, staff attendance records revealed that 38 per cent of the staff had not received training in infection prevention and control.

In interviews, staff #123, #143 and #105 stated they had not completed training in infection prevention and control in 2015.

In an interview staff #138 confirmed that 38 per cent of staff had not received training in infection prevention and control in 2015. [s. 219. (4)]

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 training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes, (a) hand hygiene; (b) modes of infection transmission; (c) cleaning and disinfection practices; and (d) use of personal protective equipment is completed, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in falls prevention and management.

A CIS report was submitted to the MOHLTC related to a fall in which resident #008 sustained an injury causing a significant change in his/her condition on the same day.

As a result of non-compliances under O. Reg. 79/10, s. 36 related to safe transferring and positioning devices or techniques when assisting residents, the home's 2015 staff education attendance records related to falls prevention and management were reviewed.

Review of the 2015 staff education attendance records revealed that 32 per cent of direct care staff had not received training in falls prevention and management.

In interviews, staff #123, #143 and #105 stated they had not completed training on falls prevention and management in 2015.

In an interview, staff #138 confirmed that 32 per cent of direct care staff had not received training on falls prevention and management in 2015. [s. 221. (1) 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 direct care staff are provided training in falls prevention and management, to be implemented voluntarily.

WN #7: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Observations during stage one of the RQI revealed unlabeled resident personal care items in shared resident rooms.

On a specified date, the inspector observed the following unlabeled resident personal care items stored in the sink areas of shared resident rooms:
- toothpaste tube, toothbrush and a denture cup with lid, blue disposable razor, and urinal.

In an interview, staff #107 stated that resident personal care items are to be labeled in shared rooms to prevent the transmission of infection.

In an interview, staff #109 who is also the Infection Control Lead confirmed that staff did not participate in the implementation of the infection prevention and control program by ensuring that resident personal care items were labeled in shared resident rooms. [s. 229. (4)]

2. On a specified date and time, at approximately 1202 hours a specified time, the inspector observed staff #100 cleaning the coffee machine station in the kitchen, without performing hand hygiene, he/she proceeded to handle food.

In an interview, staff #100 stated that he/she had forgotten to wash his/her hands after cleaning the coffee machine station.

Staff #101 present in the kitchen at the time of observation stated that staff #100 should have washed his/her hand between tasks. Staff #101 further confirmed that staff #100 had not participated in the implementation of the infection prevention and control program as he/she did not perform hand hygiene. [s. 229. (4)]

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 participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 31st day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIENNE NGONLOGA (502), ANGIE KING (644), JOANNE ZAHUR (589)
Inspection No. / No de l'inspection :	2016_377502_0017
Log No. / Registre no:	031538-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 25, 2017
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Altamont Care Community 92 ISLAND ROAD, SCARBOROUGH, ON, M1C-2P5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Saira Haq

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:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall prepare and submit a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents with transfers.

The plan shall include, but not limited to the following elements:
1. Education for all direct care staff, including:
- the different types of transfer methods and positioning devices that can be used with residents,
- the manner in which identified transfer methods are to be used to ensure resident safety,

2. A system to randomly audit resident transfer practices to ensure:
- staff are transferring and positioning residents as per the residents' individual plan of care.

Please submit the plan to Juliene.ngonloga@ontario.ca no later than February 20, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was submitted to the MOHLTC related to a fall in which resident #008 sustained an injury causing a significant change in his/her condition on the same day. The CIS further revealed that the fall occurred during an identified care using a specified device. Review of an identified documentation for resident #008 revealed that the cause of death was complications related to the injury

five months prior.

Review of the home's investigation notes revealed the following:
- Staff #137 had operated the identified device unassisted after resident #008 received an identified care,
- Staff #137 had not applied a specified safety device,
- Staff #137 revealed he/she had turned his/her back to remove the gloves and resident #008 fell,
- Staff #137 stated the specified safety device had not been working properly for some time,
- Staff #137 stated that he/she had not been provided training on how to use the specified equipment. Although staff #137's personnel file revealed that he/she had received the training and certified as transfer coach training.
- Staff #137 has been terminated as a result of the above mentioned incident.

A review of the home's preventative maintenance reports, three months prior to the incident, for the specified device revealed no areas of disrepair had been noted.

The inspector was unable to conduct an interview with staff #137 as his/her contact information, obtained from his/her personnel file, was no longer in service.

Review of the written plan of care completed on admission, revealed that resident #008 required total level of assistance with a specified care and was to be assessed prior to the activity, related to an identified medical condition. Review of Minimum Data Set-Resident Assessment Indicator (MDS-RAI) revealed resident #008 was not able to attempt sitting without physical help.

Review of a specified training record highlights for the equipment revealed the following on pages three and four:
-that a resident must be able to maintain a Dynamic Sitting Balance in an unsupported, upright seated position,
-resident must have the ability to correct their upright seated posture without assistance,
-never leave a resident unattended (do not turn your back on the resident), and
-always maintain eye contact and/or control of the resident and their actions at all times.

In an interview, representative (AHR) #165 stated that the specified device is to be used with residents that are able to maintain trunk control. AHR #165 further stated based on resident #008's assessment, his/her should not have been provided care in the specified device,.

In an interview, staff #132 stated that resident #008's medical condition did not allow him/her to be placed in the specified equipment.

In an interview, staff #154 stated that resident #008 had been provided an identified care since admission in the home due to his/her medical condition. Staff #154 further stated that the incident day was the first time that resident #008's care was changed.

In interviews, staff #142, #154 and #114 stated there had not been any reported issues with the specified safety equipment prior to the incident.

In an interview, staff #147 stated that two staff are required to be present when the identified equipment is used. Staff #147 also stated that the home's investigation notes related to the incident had been accurate, as the inspector was not able to verify the content with staff #137, who was terminated.

In an interview, staff #147 confirmed staff #137 had not used safe transferring techniques when assisting resident #008. [s. 36.] (589)

2. Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to injury in which resident #015 was transferred to hospital.

Review of resident #015's written plan of care revealed that his/her transfer status had been revised on an identified date to include the need for a two person sit-to-stand mechanical lift for all transfers.

Review of the home's investigation notes revealed that staff #108 had admitted to manually transferring resident #015 unassisted on the day of the above incident.

Observations conducted by the inspector throughout the Resident Quality Inspection (RQI) revealed that resident #015 was in bed.

In an interview, staff #108 stated that on the day of incident, resident #015 had refused to be transferred with the mechanical lift. As a result, staff #108 manually transferred resident #015 unassisted. During the transfer, a specified resident's body part buckled and staff #108 called for assistance. A second PSW assisted in seating resident #015. Staff #108 further stated that he/she should have requested the assistance of a second PSW for the above mentioned transfer.

In an interview, staff #133 stated that he/she assessed resident #015 after the incident and noted an injury. Staff #133 and # 132 stated that the transfer logo above resident #015's bed indicated the use of a sit-to-stand mechanical lift for all transfers. Staff #132 further stated the resident had required this mode of transfer for a specified health condition.

In an interview, staff #147 confirmed that staff #108 had not used safe transferring techniques with resident #015 which resulted in an injury.

The scope of this finding is isolated to two residents; the severity is actual harm / risk. The previous compliance history revealed previous non-compliances (unrelated). As a result of this noncompliance with O. Reg. 79/10, s. 36, a compliance order is warranted. [s. 36.] (589)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julienne NgoNloga

Service Area Office /
Bureau régional de services : Toronto Service Area Office