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
Jan 21, 2020	2020_643111_0002	017994-19, 022935-19, 000722-20	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

LYNDA BROWN (111)

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): January 13 to 17, 2020.

There were three complaints inspected concurrently during this inspection as follows:
- Log #017994-19 related to provision of care.
- Log #022935-19 and #000722-20 related to bed refusals.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Resident Relations Coordinator (RRC), RAI- Coordinator, Registered Practical Nurses (RPN), Personal Support Workers (PSW) and the CELHIN Case Manager.

During the course of the inspection, the inspector reviewed the health care record of a discharged resident and reviewed two admission applications.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the care plan set out, the planned care for the resident and clear directions to staff and others who provide direct care to the resident.

A complaint was received by the Director from a family member of resident #001, who had been in the homes respite program.The family indicated the resident was not provided proper care and indicated they had provided specific dietary instructions that were not followed. The family indicated the resident has since passed away.

Review of the health care record for resident #001 indicated the resident was admitted to the home on respite care. Review of the progress notes for resident #001 indicated the resident was admitted on a specified for respite care, with a family member. The resident required one staff assistance and set up with eating, personal hygiene, toileting and dressing. The resident indicated preferred bathing times and had the use of a medical device related to continence needs. The resident was on specified dietary restrictions due to a medical diagnosis. On two separate dates, the resident was encouraged to have a specified dietary intervention, as directed by the family member. A number of days later, the resident was discharged.

Review of the 24 hour Kardex (dated a specified date) for resident #001 related to bathing, hygiene/grooming needs, eating and continence care needs indicated there was no clear direction in the 24 hour Kardex related to the family`s specific dietary request or specific dietary restrictions, or the residents bathing, hygiene, grooming and continence care needs.

Review of the written care plan for resident #001 (dated a specified date) indicated under bathing, the resident's preference was for a shower, required one staff assistance and no other directions. Under eating, the resident required supervision and set up but no other directions related to dietary restrictions or specified direction by the family. Under toileting,the resident required one staff assistance and with specified medical device each shift. Under personal hygiene/grooming, required one staff assistance but no other directions provided. Under dressing, required one staff assistance. There was no clear direction in their care plan related to when the resident was to be bathed or how often, grooming needs, no indication of their continence level or care required.

Review of the point of care (POC) for resident #001 under bathing, indicated the resident was to receive two showers per week on a specified shift, despite the progress notes indicating the resident's preference was for a different specified shift.

During separate interviews with PSW #117 and #118, they both indicated if they had a new admission that they were not familiar with, they would refer to the resident's Kardex for their care needs or ask the nurse what their care needs were.

During an interview with RPN #119, they indicated when they receive a new or respite resident, they were required to update the residents initial care plan, which also created the Kardex. The RPN indicated the RAI Coordinator would complete any updates, after a specified number of days, if the resident is still in the home. The RPN indicated the PSWs are to refer to the resident's Kardex for care needs which is automatically populated into their point of care (POC).

During an interview with the RAI-Coordinator, they indicated that they would complete the admission MDS assessment after specified number of days and the nurse was required to provide the initial 24 hour plan of care, which would generate the Kardex and POC for the PSWs.

During an interview with the DOC, they indicated the expectation is that when they have a new respite resident admission, the care plan and the Kardex, is updated by the nurse within 24 hours, to provide direction to the PSWs with the resident's care needs. The DOC confirmed that resident #001 who was on a respite admission for a specified number of days, did not have their care plan or Kardex updated to indicate what the resident's care needs were related to personal hygiene/grooming and continence care needs.

The licensee failed to ensure the 24 hour care plan for resident #001, set out the planned care for the resident and clear directions to staff and others who provide direct care to the resident related to the residents eating, bathing, hygiene/grooming, dietary and continence care needs.

Issued on this 21st day of January, 2020

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

Original report signed by the inspector.