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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 13, 2021	2021_882760_0036	007738-21, 008055-21, 011575-21	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 Markham ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Altamont Care Community
92 Island Road Scarborough ON M1C 2P5

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

JACK SHI (760), LUCIA KWOK (752)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 4, 5, 6, 7, 2021.

The following intakes were completed in this critical incident inspection:

A log was related to an allegation of resident abuse;
A log was related to an allegation of resident neglect;
A follow up log to Compliance Order (CO) #001, LTCHA s. 19 (1), related to prevention of abuse and neglect, issued under inspection #2021_875501_0010, on May 10, 2021, with a compliance date of September 10, 2021, was inspected.

During the course of the inspection, the inspector(s) spoke with a care support assistant (CSA), an Environmental Team member, the Nurse Practitioner (NP), the Infection Prevention and Control (IPAC) lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Executive Director (ED) and the Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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	2021_875501_0010	760

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. 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 the staff followed the home's infection prevention and control (IPAC) practices.

Observations were conducted and noted the following:
- A PSW was observed doffing off their gloves after completing care and exiting a resident room. The PSW was then seen putting on a new pair of gloves and went into the resident's room again without performing hand hygiene. The IPAC lead indicated that if the staff member was leaving the resident's room and went into the hallways to retrieve products, they should have performed hand hygiene after removing their gloves.
- A PSW was observed to be inside a resident's room without a face shield and gloves on. The signage outside of the resident's room indicated they were on precautions and staff were required to wear their face shield and gloves. The IPAC lead stated staff should follow the signage posted outside of the resident's room.
- Three hand hygiene product machines were found to be not working. An Environmental Team Member stated that everyone was to check to ensure that these machines were always in functional status and should be flagged if one was not working.
- Two caddies outside two residents' rooms did not have the appropriate personal protective equipment (PPE) in it. Both resident rooms were on precautions as per the signage outside their door. The IPAC lead stated that any staff member who used the last PPE would be responsible for restocking the caddie with the appropriate item.
- A visitor was seen sitting next to a resident in the hallway without their mask being worn.
- An observation was conducted during the start of lunchtime and residents were being brought to the dining room areas without hand hygiene being offered, until the inspector started to ask residents if their hands were cleaned by the staff. An RPN stated that staff are to always provide hand hygiene to residents when they are brought to the dining room.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff and a visitor of the home. In addition, there were inconsistent IPAC protocols that were observed during the inspection at the home. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the IPAC lead and other staff and other staff; Observations made during the inspection. [s. 229. (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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure a resident was treated with dignity and respect by an agency PSW.

According to the home's investigation, staff had witnessed an agency PSW was being physical when they were attempting to redirect a resident. The progress notes further indicate that the resident asked them to stop but the agency PSW did not comply. The home's staff intervened, and the resident became emotionally upset. The DOC confirmed that the resident was not treated with dignity and respect by this agency PSW. As a result of the agency PSW's actions, the resident sustained emotional harm from the incident.

Sources: Home's investigation notes; Review of the resident's progress notes; Interviews with an RPN and the DOC. [s. 3. (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 the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care identified the responsive behaviours in two residents.

An incident occurred with a resident and they were emotionally harmed by an agency PSW. A review of the resident's care plan at the time of this incident did not specify information about their responsive behaviours. The resident's care plan was updated a few months after the incident had occurred. The DOC stated that this information should have been in the resident's care plan prior to this incident. Failure to have these triggers and interventions identified in the resident's plan of care may lead to staff not knowing the resident's responsive behaviours.

Sources: Review of the resident's care plan; Review of the home's investigation; Interviews with an RPN, the DOC and other staff. [s. 26. (3) 5.]

2. An interview with an RPN indicated a resident demonstrated responsive behaviours and required continued monitoring. A review of the resident's care plan did not indicate any of this information on their responsive behaviours. The DOC stated that it was the responsibility of the RPN to update the resident's care plan to ensure it had information on their responsive behaviours. Failure to have this information on the resident's plan of care may lead to unclear directions for staff who provide care for the resident.

Sources: Interviews with an RPN and the DOC; Review of the resident's care plan. [s. 26. (3) 5.]

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 A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident 5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident received sufficient changes to their continence care product to remain clean, dry, and comfortable.

A CSA told PSW #115 that the resident required continence care. After this communication, another PSW had witnessed PSW #115 providing assistance to the resident while they remained in a soiled condition. The DOC stated the home's expectation would have been for PSW #115 to have provided care to the resident when they were found to be in a soiled condition. The failure to provide sufficient continence care to the resident resulted in them being found in an undignified condition.

Sources: Home's investigation notes; Interviews with a PSW, a CSA, the DOC and other staff. [s. 51. (2) (g)]

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, (g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #5: 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to ensure an agency PSW received information on a resident's plan of care and had access to it.

An incident occurred with a resident and they were emotionally harmed by an agency PSW. The ED stated that as per the home's process, an agency PSW was supposed to receive information on a resident's plan of care from the home's staff. According to an RN, they did not recall providing any information on the resident's plan of care to this agency PSW at the start of their shift. The DOC stated they would have expected the RN to have communicated to the agency PSW on the resident's plan of care at the start of their shift. As this agency PSW did not review this resident's plan of care at the start of their shift, it resulted in them engaging in inappropriate actions with this resident, causing the resident to be emotional distressed.

Sources: Home's investigation regarding the incident; Interviews with the ED, an RN, the DOC and other staff. [s. 6. (8)]

Issued on this 15th day of October, 2021

[redacted]

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) :	JACK SHI (760), LUCIA KWOK (752)
Inspection No. / No de l’inspection :	2021_882760_0036
Log No. / No de registre :	007738-21, 008055-21, 011575-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 13, 2021
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
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Lorraine Gibson

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

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

Ordre(s) de l'inspecteur

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

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

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that all PPE caddies are fully stocked and that all caddies have all the appropriate PPE in them.

2. Ensure all hand hygiene product machines are in working order and to take immediate action if one is found to be not in a working condition.

3. Provide hand hygiene to all residents in accordance to the home's infection prevention and control (IPAC) practices.

4. Provide monitoring and supervision to all staff and essential caregivers to ensure compliance with the home's IPAC practices. Provide spot education and training to those who are not adhering with appropriate IPAC measures.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

Observations were conducted and noted the following:
- A PSW was observed doffing off their gloves after completing care and exiting a resident room. The PSW was then seen putting on a new pair of gloves and went into the resident's room again without performing hand hygiene. The IPAC lead indicated that if the staff member was leaving the resident's room and went into the hallways to retrieve products, they should have performed hand hygiene after removing their gloves.

- A PSW was observed to be inside a resident's room without a face shield and gloves on. The signage outside of the resident's room indicated they were on precautions and staff were required to wear their face shield and gloves. The IPAC lead stated staff should follow the signage posted outside of the resident's room.
- Three hand hygiene product machines were found to be not working. An Environmental Team Member stated that everyone was to check to ensure that these machines were always in functional status and should be flagged if one was not working.
- Two caddies outside two residents' rooms did not have the appropriate personal protective equipment (PPE) in it. Both resident rooms were on precautions as per the signage outside their door. The IPAC lead stated that any staff member who used the last PPE would be responsible for restocking the caddie with the appropriate item.
- A visitor was seen sitting next to a resident in the hallway without their mask being worn.
- An observation was conducted during the start of lunchtime and residents were being brought to the dining room areas without hand hygiene being offered, until the inspector started to ask residents if their hands were cleaned by the staff. An RPN stated that staff are to always provide hand hygiene to residents when they are brought to the dining room.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff and a visitor of the home. In addition, there were inconsistent IPAC protocols that were observed during the inspection at the home. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the IPAC lead and other staff and other staff; Observations made during the inspection.

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

Severity: There was actual risk of harm to the residents as there was potential for possible transmission of infectious agents due to non compliance identified from the home's IPAC program.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: In the last 36 months, the licensee was found to be non compliant with s. 229 (4) of O. Reg 79/10, and three WNs, two VPCs, one CO was issued to the home. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 01, 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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 October, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jack Shi

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