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

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Original Public Report

Report Issue Date September 19, 2022
Inspection Number 2022_1012_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 Markham ON L3R 0E8
Long-Term Care Home and City
Altamont Care Community, Scarborough

Lead Inspector
Amandeep Bhela [746]

Additional Inspector(s)
Tiffany Forde [741746]

Inspector Digital Signature
Amandeep Bhela
Digitally signed by Amandeep Bhela
Date: 2022.09.29 09:17:10 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 15,16,19 and 23-26, 2022.

The following intake(s) were inspected:

- Log #004790-22, follow up to Compliance Order (CO) #001, O. Reg. 79/10, s. 229 (4) related to Infection Prevention and Control (IPAC), issued under inspection #2022_947752_0002 on February 25, 2022, with a compliance due date of April 15, 2022.
- Log #013191-22, Log #012368-22 and Log #005630-22 related to resident fall.

- The following intake was completed in the Critical Incident System Inspection: Log #005038-22 related to resident fall.

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	229 (4)	2022_947752_0002	001	746

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION [MAINTENANCE SERVICES]

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.96 (2) (b)

The licensee failed to ensure that resident #003's device was in working order prior to use with the resident.

Rationale and Summary

Inspector #741746 observed resident #003 sitting in the hallway with their falls prevention intervention not applied correctly. PSW #101 checked and confirmed that a portion of the device was missing and therefore was not functioning.

Resident #003's care plan indicated that they were at high risk for falls and this intervention was to be applied.

ADOC #118 acknowledged this and indicated that the staff needed to ensure that the intervention was applied appropriately prior to use.

As a result of this the resident was put at risk, as staff may not be able to prevent or respond to a fall in a timely manner.

Sources: Observations, resident #003's care plan, Interviews with PSW #101 and ADOC #118.

[741746]

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.102 (2) (b)

The licensee failed to implement the Infection Prevention and Control standard issued by the Director.

Rationale and Summary

In accordance with O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to infection prevention and control. The Infection Prevention and Control (IPAC) standard for Long-Term Care Homes as of April, 2022, provided additional requirements for IPAC programs in long-term care homes.

An observation was conducted where 11 bottles of Alcohol-based hand rub (ABHR) were noted to be expired. Inspector #746 noted expired ABHR being used by staff in the dining room and being provided to residents, prior to lunch. Furthermore, observations, noted staff #100 was wearing their mask under their chin, with another staff member present in the vicinity.

IPAC lead indicated that it was unsafe to use ABHR that were expired as it would be difficult to determine their alcohol content. The IPAC lead indicated that masks were required to cover their mouth and nose.

As a result of this, there was risk of spreading infectious agents, such as, COVID-19 to residents.

Sources: Observations, interviews with staff #100 and ADOC #118.

[746]

WRITTEN NOTIFICATION [FALLS PREVENTION AND MANAGEMENT]

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.54 (2)

The licensee failed to ensure that resident #001's required assessment was completed.

Rationale and Summary

A CIS report was submitted to the Director regarding the resident's fall with an injury. The resident's progress notes indicated that they sustained a fall, where a required assessment was not completed.

Registered Nurse (RN) #117, acknowledged that the assessment was not completed, as they were busy that day and forgot. ADOC #118, also confirmed that the assessment was not completed for the resident, and indicated that it should have been completed.

As a result of this, there was potential risk for future falls as interventions and prevention strategies were not discussed related to this fall.

Sources: Resident #001's progress notes, risk management, interviews with RN# 117 and ADOC #118

[746]

WRITTEN NOTIFICATION [FALLS PREVENTION AND MANAGEMENT]

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.54 (2)

The licensee failed to ensure that resident #001's was appropriately monitored as per the home's falls prevention and management program.

Rationale and Summary

A CIS Report was submitted to the Director regarding the resident's fall with an injury, the CIS Report indicated what occurred at the time of the fall.

A review of the resident's progress notes, post fall assessment and interview's with PSWs #110, #114, #117 and RN #115 indicated a different occurrence of events. RN #115 indicated that they misunderstood what was reported to them at the time of the fall, which resulted in the RN not completing a required fall's assessment as per the home's fall program.

ADOC #118, confirmed that this assessment should have been completed, after the fall.

As a result of this, there was potential risk as the resident was not monitored appropriately post fall.

Sources: Resident #001's progress notes, risk management, interviews with PSW#110, #114, RN#115 and ADOC #118.

[746]