Ontario

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

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

Central East District
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Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: July 5, 2023

Inspection Number: 2023-1012-0003

Inspection Type:
Complaint
Critical Incident System

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

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

Lead Inspector	**Inspector Digital Signature**
Amandeep Bhela (746)	Amandeep Bhela Digitally signed by Amandeep Bhela Date: 2023.07.11 12:58:55 -04'00'

Additional Inspector(s)
Ana Best (741722)
Holly Wilson (741755)
Jacqueline Smith (000740)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 5, 6, 8, 9,12-14, 2023
The inspection occurred offsite on the following date(s): June 7, 2023

The following intake(s) were inspected:

- Intake: #00019852 - related to responsive behaviours.
- Intake: #00084589 - Complaint related to missing items and abuse and neglect.
- Intake: #00085270 and Intake: #00088231 related to abuse
- Intake: #00085289 - Complaint related to falls.
- Intake: #00085959 - related to skin and wound.
- Intake: #00086247 - Complaint related to falls and availability of supplies.

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

Continence Care
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The Licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

Rationale and Summary:

A complaint was received by the Director which indicated concerns regarding a resident's plan of care.

A review of a resident's care plan confirmed that the care plan was not updated to reflect resident preferences around meals, recreational activities, socialization needs, an identified fall prevention intervention and skin and wound intervention.

Interview's with Personal Support Worker(PSW) #124 and Registered Practical Nurse(RPN) #122, Activation Aide (AA) #125, Physiotherapist #127, staff #128 confirmed that the care plan was not updated.

Failure to ensure that the resident's care plan is reflective of their needs and preferences, put the resident at risk of physical and psychosocial harm.

Sources: Complainant, resident #007" progress notes and care plan, interviews with staff. [741755]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL LEAD

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-Compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure that the home has an Infection Prevention and Control Lead (IPAC) whose primary responsibility is the home's infection prevention and control program.

Rationale and Summary

A record review was conducted which indicated that the home's designated IPAC Lead resigned their position and last worked on May 19, 2023.

Interview with the Associate Director Of Care (ADOC) #110 indicated that the previous IPAC Lead resigned, so they assist with completing audits and delivering supplies however they confirmed they are not the home's IPAC Lead and IPAC is not their primary responsibility.

Failing to ensure that the home had an IPAC Lead had potential to impact the implementation of policies and procedures related to the IPAC program, increasing the risk for the possible spread of infections in the home.

Sources: Record and Interview with ADOC #110.
[746]

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect resident a resident from another resident.

Section 2 (1) of the Ontario Regulation 246/22, defines "Sexual abuse" as any consensual or non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member or any non-consensual touching, behavior or remarks or a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary

A Critical Incident Report (CIR) report was submitted to the Director for an allegation of sexual abuse by a resident towards a co-resident.

A review of the residents' #005 and #006 clinical records indicated that on the identified date, both residents were sitting together. PSW #105 witnessed resident #005 displaying inappropriate behavior towards resident #006.

During an interview with the resident, resident confirmed the incident had occurred.

PSW #105 confirmed they have witnessed the incident and immediately reported to RPN #106.

RPN #106 and Registered Nurse (RN) #107, confirmed both residents were separated immediately, and an assessment tool was initiated for resident #005.

The Behavioural Supports Ontario (BSO) lead and the DOC acknowledged that the act of resident #005 towards resident #006 was considered sexual abuse.

Failing to protect resident #006 from sexual abuse from resident #005, put resident #006's physical and emotional health at risk.

Sources: CIR # 0956-000017-23, resident's clinical records, interview with resident #005, PSW# 105, registered staff #106 and #107, BSO lead and DOC.
[741722]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the home's written policy on zero tolerance for abuse was complied with.

Rationale and Summary

A CIR report was submitted to the Director for an allegation of sexual abuse by a resident towards co-resident.

The home's policy titled, "Prevention of Abuse and Neglect of a Resident Policy", last revised 10/2022 indicated that "All team members and families with reasonable grounds to suspect abuse of a resident are required to report to the provincial health authorities and the Executive Director or designate in charge of the community. Abuse that is to be reported: b. Abuse of a resident by anyone or neglect of a resident by the licensee or staff (team member(s)) that resulted in harm or a risk of harm to the resident."

Resident #006's incident note, created by registered staff # 106 confirmed PSW #105 witnessed inappropriate behavior from resident #005 towards resident #006.

The DOC stated registered staff on shift are to immediately report to the ADOC, DOC, Executive Director, or Manager on call any case of abuse. The DOC confirmed they were notified on an identified date after the incident had occurred, during morning report about the witnessed sexual abuse incident. In addition, the DOC indicated registered staff #106 and #107 failed to comply with the home's zero tolerance of abuse and neglect policy when they didn't report the sexual abuse of resident #006 immediately.

Failing to ensure the policy to promote zero tolerance of abuse and neglect was complied with, increased the risk of ongoing abuse.

Sources: CIR # 0956-000017-23, Prevention of Abuse and Neglect of a Resident policy, resident #006's clinical records, interview with DOC.
[741722]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27

The licensee failed to ensure that an alleged incident of resident-to-resident abuse was immediately investigated.

Summary and Rationale

A Critical Incident was reported to the Director for an allegation of resident-to-resident physical abuse

Record review indicated that an allegation of physical abuse of a resident towards another resident.

Review of a resident's progress notes indicated no documented investigation.

Interview with RN #127 confirmed that the resident received an assessment but did not initiate an immediate investigation. RN #127 also confirmed that they did not call the police. In an interview, the Administrator confirmed that an investigation should have been immediately initiated, and the police should have been informed of the incident. Interview with BSO RPN #126 confirmed that BSO was aware of this incident and acknowledged that no documentation or investigation had occurred.

Failure to immediately investigate an allegation of abuse resulted in the resident being placed at risk for further abuse.

Sources: CIR #3057-000028-22, resident #007's progress notes and care plan, interviews with staff.

[741755]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that, where the Act required the licensee of a LTCH to carry out every operational Minister's Directive that applies to the LTCH, the operational Minister's Directive was complied with.

In accordance with the Minister's Directive, COVID-19 guidance document for LTCH's in Ontario, dated June 29, 2022, licensee was required to IPAC self-audits every two weeks when the home was not in COVID-19 outbreak.

Rationale and Summary

A review of IPAC audits was conducted from January 3, 2023 to June 6, 2023. The home did not have records of the IPAC audits for the week of April 23- 29, 2023 and May 7 -13, 2023. The ADOC confirmed they could have been missed and they could not verify if the IPAC audits were completed during that time.

Sources: The COVID-19 Guidance Document for Long-Term Care Homes in Ontario, the

home's IPAC self-audit records and interviews with ADOC #110.
[746]

WRITTEN NOTIFICATION: AVAILABILITY OF SUPPLIES

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 48

The licensee failed to ensure that linen supplies were readily available at the home to meet the nursing and personal care needs of residents.

Rationale and Summary

A complaint was submitted to the Director indicating that there was a concern around not enough linen being readily available for staff to provide resident care, it was indicated that often the linen cart was prepared with the required number of linens.

On June 6, 2023, Wing 2 linen cart was brought to the unit by PSW #112. PSW #112 confirmed that this is an ongoing issue at the home and proceeded to show the number of linens delivered to the unit. The linen cart was delivered with one face cloth and 16 bath towels. PSW #112 and PSW #116 indicated that this is not sufficient supply for us to provide care to the residents.

Interview with Director of Environmental Services (DES) confirmed that the home does have an issue with linens, and that the process is being re-evaluated to ensure that staff receive sufficient supply of linens.

Failure to ensure that linen supplies are readily available for staff at the home, poses a risk to the delivery of nursing and resident personal care needs.

Sources: Observation on Wing 2, Interviews with PSW #112, #116, and DES #104. [746]
[746]

WRITTEN NOTIFICATION: Notification re Incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Rationale and Summary:

A CIR was submitted to the Director in which an alleged incident of abuse took place involving a resident towards a co-resident.

An altercation occurred where a resident hit another resident. Resident #009's SDM was not contacted. The SDM had provided the contact information to the home and is documented on the resident's electronic health record.

The homes' Prevention of Abuse Checklist for Investigating Alleged Abuse indicates to immediately notify the SDM of the incident if the resident is not capable including the ongoing investigation with assurances to update regularly.

Upon record review of the progress notes of the resident, there was no evidence that the SDM was contacted by the home, about the alleged abuse.

Interview with RN #113 confirmed that any registered staff, Social Worker (SW) or management can contact the SDM if needed. RN #113 and DOC confirmed that for a resident, the SW is to contact the POA, however this is not recorded on the resident's electronic health record. Interview with the SW #119 confirmed that they did not initiate contact, however any registered staff can contact any SDM if needed. Interview with the DOC confirmed that any registered staff can contact the SDM, however there is no record of any contact with the SDM.

Failure to communicate with the SDM places the resident at increased risk of detriment of health, well- being and advocacy of quality of life.

Sources: CIR #0956-000006-23, resident #009's electronic health record, the home's Prevention of Abuse Checklist for Investigating Alleged Abuse, interviews with RN #113, SW #119 and DOC.
[741755]