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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 12, 2017;	2017_543561_0004 (A1)	006728-15, 022013-15, 029391-15, 029644-15, 032926-15, 002507-16, 004594-16, 005920-16, 008695-16, 012095-16, 019984-16, 021952-16, 031873-16, 035233-16, 002164-17	Critical Incident System

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

Camilla Care Community
2250 HURONTARIO STREET MISSISSAUGA ON L5B 1M8

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

DARIA TRZOS (561) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): February 13, 14, 15, 16, 17, 21, 22, 27, 28, March 1, 2, 3, 7, 2017

Concurrent Critical Incident Inspection was completed during this inspection with the following log number:

032158-16 - fall with injury

Concurrent Complaint Inspections were completed during this inspection with the following log numbers:

018012-15 – injuries of unknown cause

032568-16 – improper care, quality of food

034644-16 – care issues, continence care, dietary services, temperature, laundry

001338-17 – temperatures, furnishings, abuse and neglect, care issues

034129-16 – nail care, mobility equipment, falls, activities

Concurrent Inquiries were completed during this inspection with the following log numbers:

034882-16 – resident's rights, responsive behaviours

001075-17 – medication, temperatures

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOCs), Director of Environmental Services, Residents Relations Coordinator, Director of Dietary Services, Physiotherapist, Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) nurse, Personal Support Workers (PSW) and BSO PSW.

During the course of the inspection, the inspectors observed the provision of care, reviewed health care records, and reviewed relevant policies, procedures and practices.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Falls Prevention

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **2 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 LTCHA, 2007, 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. (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 :

(A1)
1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #006 was a frequent faller with a number of documented falls in 2015 and 2016. Resident had an intervention implemented to prevent the falls; however the health care records when reviewed indicated that the written plan of care did not include this intervention. The registered staff in the home and ADOC #102 confirmed that the written plan of care sets out the planned care for residents and

all interventions implemented should be listed on the written plan of care to ensure staff know what care to provide for residents.
The written plan of care did not set out the planned care for the resident in relation to falls. [s. 6. (1) (a)]

2. 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) Clinical health record review revealed that there was a complaint made to management at the home related to lack of care provided by PSW #121 to resident #022 on an identified date in 2016.
Observations by an LTC Inspector revealed resident #022 could not be interviewed related to cognitive impairment.
The resident's most recent plan of care addressed the interventions for personal hygiene, transfers, continence care and falls.
In an interview, PSW #121 indicated the unit had been short-staffed, and they had been assigned to care for the resident. The PSW stated they were not aware of the resident's care needs. They stated they were unaware the resident had fallen and injured themselves. The PSW further admitted that they did not refer to the resident's written plan of care for direction.
In an interview, registered staff #121 who was in charge on the day of the incident, and the DOC confirmed the care was not provided to the resident as per their written plan of care.
A review of the home's investigation notes indicated PSW #120 received disciplinary action as a result of the incident.

The licensee did not ensure that care set out in the plan of care was provided to resident #022 as specified in their written plan of care. (591)

B) Resident #009 had a plan of care indicating that they were at high risk for falls and had a device in place as an intervention while in bed. Resident sustained a fall on an identified date in 2016. The progress notes indicated that resident had removed the device. The written plan of care indicated that the resident required a different type of a device to be applied as an intervention. Health care records indicated that resident #009 fell in their room on an identified date in 2016 and sustained an injury. Progress notes and the post fall assessment indicated that the resident had a different device in place and not the one specified in the plan of care. The post fall assessment also indicated that the device was not attached as it should have been. The ADOC #102 was interviewed and stated that there was a

delay in implementing the new device and the intervention in place as per the plan of care was not provided to the resident at the time of the fall.
The ADOC #102 confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan.

C) The plan of care for resident #002 identified the resident as being at high risk for falls and having history of falls prior to an identified date in 2015. On an identified date in 2015, resident sustained a fall with an injury and was sent to the hospital. One of the interventions implemented by the home after the fall, as indicated in the written plan of care, was a device and staff to check it to ensure that it was in working condition and properly applied. On an identified date in 2015, resident sustained another fall that resulted in an injury. The progress notes indicated that the device did not have batteries and was not in use. PSW #111 was interviewed and stated that they assisted the resident with care on that day, resident was in bed when the PSW left the room,during that time the resident got up from bed and fell. The PSW indicated that they were not done with providing care and when returned the resident was on the floor; the device did not activate and when they checked it, the batteries were not working. ADOC #102 was interviewed and indicated that it was the responsibility of the PSWs to check and ensure that the device was functioning.

The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan ensuring that the device used was in working condition. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) Resident #003 had a plan of care indicating that they were ambulatory with a walker and were assessed to be at high risk for falls. Resident had a fall on an identified date in 2015 and sustained an injury. Resident was sent to the hospital for an assessment. When resident returned from the hospital they were assessed by Physiotherapist. Based on the assessment they had recommended implementation of a device as an intervention. Physiotherapist was interviewed on February 2, 2017, and confirmed that they recommended that specific intervention for the resident on an identified date in 2015, and discussed it with the registered staff. Registered staff were responsible for revising the care plan once the

intervention was implemented.

The health care record review revealed that the intervention recommended by the Physiotherapist was not added to the written plan of care as an intervention for falls at that time. The Point of Care (POC) was reviewed and revealed that the interventions was not added to the POC for PSW to document application of it, at that time.
Resident sustained another fall on an identified date in 2015. Registered staff #119 was interviewed and stated that they could not recall if the resident had the device in place at the time of the fall.
The investigation notes and the Critical Incident Report were reviewed and did not mention the implementation of the device as an intervention for falls. The ADOC #102 and the DOC confirmed that the care plan was not revised with the intervention recommended by the physiotherapist.

B) Resident #010 had a plan of care indicating that they were considered as high risk for falls. On an identified date in 2016 registered staff witnessed the resident fall. No injuries were sustained after this fall. One of the interventions listed on the post fall huddle assessment form was to always monitor the resident. The written plan of care at the time of the fall did not specify that resident required to be monitored at specific times during specific tasks.
The Critical Incident report submitted to the Director indicated that on an identified date in 2016, resident fell and sustained an injury.
The health care records indicated that resident #010 was assisted to the bathroom and left the resident while attending to another resident. The PSW #116 was interviewed and stated that they followed the plan of care for resident.
Health care records were reviewed and indicated that the intervention to not leave resident unattended in the bathroom was not added until the day after the fall. he ADOC #100 was interviewed and confirmed that it was an expectation that the staff not leave the resident unattended on the toilet due to the high risk for falls and the care plan was not revised until after the resident fell. [s. 6. (10) (b)]

4. The licensee has failed to ensure that when the resident was reassessed and the plan of care was revised because care set out in the plan was not been effective, different approaches were considered in the revision of the plan of care.

Resident #006 had a history of falls with a number of documented falls in year 2015 and 2016.
Health care record review indicated that resident's falls in 2015 were reviewed by

the Falls Committee during the monthly meetings and one of the interventions was discussed at all of the monthly meetings between August 2015 and January 2016. Resident was not a candidate for the nursing rehabilitation program and no other interventions were tried.

Registered staff #120 and #105 were interviewed during the inspection. During the interview, registered staff #120 stated that the resident was cognitively impaired and interventions as specified in the plan of care were not effective for them. The registered staff confirmed that one intervention has been in place for some time and no other interventions were tried.

On an identified date in 2016 resident fell and sustained an injury. Resident's health condition deteriorated after the fall and they passed away.

The DOC confirmed that the interventions in the plan of care were not effective for resident #006 and no other interventions were tried.

The licensee failed to ensure that different approaches were considered for resident #006 to prevent them from falling. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001,002

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, and to 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 the resident's care needs change or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Regulation 48 (1) of the Long Term Care Homes Act, 2007 states that every licensee of the a long term care home shall ensure that the falls prevention and management program is developed and implemented in the home and regulation 48 (2) (a) and (b) of the Long Term Care Homes Act, 2007, states that the program must provide for screening protocols and assessment and reassessment instruments.

The home's policy titled "Falls Prevention", policy number VII-G-30.00, revised January 2015, directed the staff to initiate the head injury routine (HIR) if a head injury is suspected or if the resident fall is unwitnessed and he/she is on anticoagulant therapy.

A) Resident #009 sustained an unwitnessed fall on an identified date in 2016. The health care records were reviewed and indicated that the HIR was not initiated and could not be found in resident's chart. In an interview, the ADOC #102 stated that the HIR was required to be initiated for unwitnessed falls, and falls with suspected head injuries. The ADOC #102 confirmed that the HIR was not initiated after the fall.

B) Resident #008 sustained an uwitnessed fall on an identified date in 2017. Health records were reviewed and a HIR could not be found. The Leisureworld Falls Incident-Post Fall Huddle indicated that the HIR was not initiated. The registered staff #105 and #115 were interviewed and confirmed that the HIR was not initiated and it should have been since this was an unwitnessed fall. ADOC #102 stated that the HIR was required to be initiated for unwitnessed falls, and falls with suspected head injuries.

C) Resident #007 sustained an unwitnessed fall on an identified date in 2016. The health care records were reviewed and the HIR could not be located. The ADOC #102 stated that the HIR was required to be initiated for unwitnessed falls, and falls with suspected head injuries and confirmed that one was not initiated after the fall.

The licensee has failed to ensure the the home`s Falls Prevention policy was complied with. [s. 8. (1) (a),s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff in the home used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions.

The health record review and interview with registered staff #120 and #112, ADOC #102 and DOC revealed that the home used a Posey bed / wheelchair alarms in the home as an intervention to prevent falls. The interview with the ADOC #102 and DOC indicated that based on few incidents where these bed alarms did not activate, the home decided to change these alarms into new ones. The home had changed most of the Posey alarms to the newer Curbell alarms, which were now easier to use and the home had no issues with functionality of the alarms since then. The ADOC #102 stated in an interview, that the staff did not know how to turn on the older Posey alarms and in some cases the alarms did not activate even though the PSWs thought they turned them on. The DOC stated that they had provided in services for PSWs on proper application of the posey alarms; however not all PSWs were provided training. The DOC was not able to confirm how many PSW staff attended the in services. On March 14, 2017, the ADOC confirmed that the home had completed an audit of all the bed / wheelchair alarms used in the home and there were still five residents that currently used the older Posey alarms. Registered staff #120 stated in an interview that there were no manufacturer's instructions on the home areas for the use of the Posey alarms. The ADOC and the DOC confirmed that the manufacturer's instructions for the older Posey alarms were not kept in the home.

The licensee failed to ensure that the staff in the home used the equipment for prevention of falls in accordance with manufacturer's instructions. [s. 23.]

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 in the home use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident who demonstrated responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A) A review of the home's internal investigation notes and clinical health records indicated that there were two incidents of resident #015 having an altercation with resident #016 causing an injury. Both residents had diagnosis of moderate dementia.
Observations by an LTC Inspector on March 6 and 7, 2017, revealed neither resident could be interviewed related to significant cognitive impairment.

In an interview, Behavioural Supports Ontario (BSO) PSW #125, and registered staff #120 confirmed Dementia Observational System (DOS) monitoring when

indicated was to be completed by registered staff, who were expected to document on the "Dementia Observational System" form, every 30 minutes, on every shift for seven days.
A review of the progress notes for residents #015 and #016 related to the above mentioned altercations, indicated the nursing staff had initiated DOS monitoring as per the home's assessment procedure for responsive behaviour management, however; a review of the clinical health records for resident #015 and #016 revealed DOS monitoring documentation could not be located. This was confirmed by ADOC #100.

The licensee failed to ensure that for each resident who demonstrated responsive behaviours, interventions were documented. (591)

B) A review of the home's internal investigation notes and clinical health records indicated separate incidences of sexually inappropriate behaviours had occurred between residents #018, #019, and #020. All three residents had been deemed to have dementia, and moderate cognitive impairment and were not able to consent.

The first incident occurred on an identified date in 2016, where resident #019 was found by staff to be engaged in sexually inappropriate behaviours towards resident #020 in a room on the unit. Two similar incidents occurred between resident #019 and resident #018 in 2016. In all three incidences, no injury was noted on assessment, families of the resident's were notified and authorities were contacted, however; no criminal charges were filed.

Observations by an LTC Inspector on March 6 and 7, 2017, revealed none of the residents could be interviewed related to significant cognitive impairment.
In an interview staff on the unit confirmed there had been significant cognitive and physical decline of all three residents since the above mentioned incidents.

In an interview on March 7, 2015, BSO PSW #125, and registered staff #120 confirmed DOS monitoring when indicated was to be completed by registered staff, who were expected to document on the "Dementia Observational System" form, every 30 minutes, on every shift for seven days. They further confirmed PSW staff were expected to document resident behaviours in Point of Care (POC) flow sheets every shift.
A review of resident #019's DOS monitoring sheets related to the above mentioned incidents revealed documentation was not completed by the registered staff for a number of hours on an identified date in 2015, and DOS monitoring could not be

located for the incident that occurred on an identified date in 2016.
A review of the POC flow sheets for resident #019 related to the above mentioned incidents revealed documentation was not completed by the PSW on one of the shift for the entire month in 2016 and on one of shift during another month in 2016.

In an interview, ADOC #100 and the DOC confirmed the documentation should have been completed. (591)

C) Resident #023 was admitted to one of the units in the home on an identified date in 2015. Interview with the registered staff #119 indicated that it was the home's expectation that DOS monitoring was to be initiated for seven days on all residents that are newly admitted to the home and when residents demonstrate responsive behaviours. A review of resident #023's health records revealed that DOS was initiated in 2015; however documentation was not completed by registered staff for a number of hours on identified dates in 2015. Resident #023 demonstrated responsive behaviours on an identified date in 2016 and registered staff initiated DOS monitoring. DOS monitoring sheets revealed that documentation was not completed by registered staff for a number of hours on an identified dates in 2016.
In an interview, ADOC #100 and the DOC confirmed the DOS documentation should have been completed.

D) Resident #023 was admitted to the home on an identified date in 2015. The New Admission Information assessment indicated that the resident had responsive behaviours. Resident #024 was admitted to the room that was shared with resident #023 on an identified date in 2016. Progress notes indicated that on an identified date in 2016, resident #023 tried to hit resident #024; however staff managed to intervene. Resident #023 was placed on DOS monitoring. Health care record review and interview with Behavioural Supports Ontario (BSO) nurse and indicated that there were identified triggers for resident #023's behaviours and an intervention was implemented to prevent these beahviours.
The plan of care was reviewed for resident #023 and behavioural triggers were not documented in the plan of care.
The DOC confirmed that the behavioural triggers should have been documented in the care plan.

The licensee failed to ensure that for each resident who demonstrated responsive behaviours, interventions were documented. [s. 53. (4) (c)]

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 behavioural triggers are identified for the resident demonstrating responsive behaviours and to ensure that, for each resident who demonstrates responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that the procedures and interventions developed were implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimized the risk of altercations and potentially harmful interactions between and among residents.

The home’s "Responsive Behaviours Management" program, policy number V3-092, originated March 2012, indicated that the registered staff were to implement behaviour tracking tool when necessary. The interview with the Responsive Behaviour Lead/ADOC #100 indicated that the Dementia Observational System (DOS) was to be initiated when an incident related to responsive behaviour occurs or when a resident displays a new responsive behaviour, for example, a new demonstrated behaviour of resistance to care.

In an interview, registered staff #119 stated that the resident #023 was usually calm, easy to be redirected; however at the beginning of the night shift on an identified date in 2016, resident was agitated and could not be redirected. During the same shift resident was observed having a behaviour towards resident #024. Registered staff #119 indicated that DOS must have been completed since the resident was on it for some time. Health care records were reviewed and confirmed that DOS monitoring was not initiated. The ADOC #100 confirmed that the DOS was to be initiated when resident exhibited responsive or unusual behaviours.

The licensee failed to ensure that DOS monitoring was initiated as per the home’s expectation. [s. 55. (a)]

Issued on this 12 day of May 2017 (A1)

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

Ministère de la Santé et 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 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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Name of Inspector (ID #) / Nom de l'inspecteur (No) : DARIA TRZOS (561) - (A1)

Inspection No. / No de l'inspection : 2017_543561_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 006728-15, 022013-15, 029391-15, 029644-15, 032926-15, 002507-16, 004594-16, 005920-16, 008695-16, 012095-16, 019984-16, 021952-16, 031873-16, 035233-16, 002164-17 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : May 12, 2017;(A1)

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 : Camilla Care Community
2250 HURONTARIO STREET, MISSISSAUGA, ON, L5B-1M8

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Name of Administrator / Nom de l'administratrice ou de l'administrateur : Lilibeth Medina

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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 :

LTCHA, 2007, 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

(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).

Order / Ordre :

(A1)
The licensee shall develop, submit and implement a plan to ensure that all residents are reassessed and the plan of care reviewed and revised when 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. The plan shall address the following:

1. Review of the listed interventions for resident #006 and all other residents that are at risk for falls. Include evaluation of the effectiveness of the interventions using an interdisciplinary approach.
2. Ensuring proper documentation is kept of the revisions and evaluations of falls interventions for resident #006 and all other residents that are at risk for falls.
3. Ensuring strategies and interventions in place for resident #006 and other residents at risk for falls are reflected appropriately in their written plans of care.

The compliance plan is to be emailed to Daria Trzos - Nursing Inspector at Daria.Trzos@ontario.ca by June 15, 2017.

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

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual Harm
Scope: Isolated
Compliance history: Non compliance was issued in a similar area, related to s. 6 of the Act on February 23, 2017 as a VPC, on February 26, 2016 as a VPC, on May 5, 2015 as a VPC, and on January 14, 2015 as a VPC.

2. The licensee has failed to ensure that when the resident was reassessed and the plan of care was revised because care set out in the plan was not been effective, different approaches were considered in the revision of the plan of care.

Resident #006 had a history of falls with a number of documented falls in year 2015 and 2016.
Health care record review indicated that resident's falls in 2015 were reviewed by the Falls Committee during the monthly meetings and one of the interventions was discussed at all of the monthly meetings between August 2015 and January 2016. Resident was not a candidate for the nursing rehabilitation program and no other interventions were tried.
Registered staff #120 and #105 were interviewed during the inspection. During the interview, registered staff #120 stated that the resident was cognitively impaired and interventions as specified in the plan of care were not effective for them. The registered staff confirmed that one intervention that has been in place for some time and no other interventions were tried.
On an identified date in 2016 resident fell and sustained an injury. Resident's health condition deteriorated after the fall and they passed away.
The DOC confirmed that the interventions in the plan of care were not effective for resident #006 and no other interventions were tried.
The licensee failed to ensure that different approaches were considered for resident #006 to prevent them from falling.
(561)

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

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

Ministère 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

Sep 15, 2017(A1)

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A1)
The licensee shall develop, prepare and implement a plan to ensure that the care set set out in the plan of care is provided to the residents as specified in the plan. The plan shall include, but is not limited to the following:

1. Audit of all care plans for residents that are at risk of falls and revision of the care plans to ensure that proper interventions are in place to prevent falls.
2. Education for direct care providers and ensuring that 100% of direct care providers had completed the education on proper application of the bed / wheelchair alarms. Ensuring that manufacturer's instructions for the application of the alarms are kept on each home area.
3. Implementation of a process in the home to ensure that the alarms are in working condition and are checked to ensure they are in working condition.

The compliance plan is to be emailed to Daria Trzos - Nursing Inspector at Daria.Trzos@ontario.ca by June 15, 2017.

Grounds / Motifs :

1. Judgement Matrix:
Severity: Actual Harm
Scope: Isolated
Compliance history: This non compliance was issued as a VPC on February 26, 2016, on May 5, 2015 and January 14, 2015

2. The licensee has failed to ensure that the care was provided to the resident as specified in the plan.

A) The plan of care for resident #002 identified the resident as being at high risk for falls and having history of falls prior to an identified date in 2015. On an identified date in 2015, resident sustained a fall with an injury and was sent to the hospital. One of the interventions implemented by the home after the fall, as indicated in the written plan of care, was a device and staff to check it to ensure that it was in working condition and properly applied. On an identified date in 2015, resident sustained another fall that resulted in an injury. The progress notes indicated that the device did not have batteries and was not in use. PSW #111 was interviewed and stated that they assisted the resident with care on that day, resident was in bed when the PSW left the room, during that time the resident got up from bed and fell. The PSW indicated that they were not done with providing care and when returned the resident was on the floor; the device did not activate and when they checked it, the batteries were not working. ADOC #102 was interviewed and indicated that it was the responsibility of the PSWs to check and ensure that the device was functioning. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan ensuring that the device used was in working condition.

B) Resident #009 had a plan of care indicating that they were at high risk for falls and had a device in place as an intervention while in bed. Resident sustained a fall on an identified date in 2016. The progress notes indicated that resident had removed the device. The written plan of care indicated that the resident required a different type of a device to be applied as an intervention. Health care records indicated that resident #009 fell in their room on an identified date in 2016 and sustained an injury. Progress notes and the post fall assessment indicated that the resident had a different device in place and not the one specified in the plan of care. The post fall assessment also indicated that the device was not attached as it should have been. The ADOC #102 was interviewed and stated that there was a delay in implementing the new device

and the intervention in place as per the plan of care was not provided to the resident at the time of the fall.
The ADOC #102 confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. (561)

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

Sep 15, 2017(A1)

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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
Toronto ON M5S 2B1
Télécopieur : 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 12 day of May 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARIA TRZOS - (A1)

Service Area Office /
Bureau régional de services : Hamilton