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 #/ No de registre	Type of Inspection / Genre d'inspection
Feb 01, 2018;	2017_543561_0015 (A1)	023982-17	Resident Quality Inspection

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

Camilla Care Community
2250 HURONTARIO STREET MISSISSAUGA ON L5B 1M8

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

Ontario

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DARIA TRZOS (561) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home received an extension to comply the order.

Issued on this 1 day of February 2018 (A1)

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

Original report signed by the inspector.

Ontario

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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 Resident Quality Inspection.

This inspection was conducted on the following date(s): October 19, 20, 23, 24, 25, and 26, 2017.

The following inspections and inquiries were conducted concurrently with this Resident Quality Inspection (RQI) and any findings are included in this RQI report:

Two Follow Up (FU) Inspections with the following log numbers:

009446-17 - related to plan of care related to falls

009447-17 - related to plan of care related to falls

Complaint Inspections with the following log numbers:

005148-17 - related to continence care

007200-17 - related to care and consent

007736-17 - related to allegation of retaliation

Critical Incident System (CIS) inspections with the following log numbers:

006879-17 - related to allegation of neglect and failure to assess

011363-17 - related to falls

017466-17 - related to alleged staff to resident abuse

The following inquiries were completed during this inspection:

019899-17 and 022156-17 - related to multiple care concerns and housekeeping

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 Programs, Physiotherapist, Registered staff including Registered Nurses (RNs), and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), President of Residents' Council, former President of Family Council, residents, and families.

During the course of the inspection, the inspectors toured the home, observed the provision of care, reviewed clinical health records, and reviewed other documents that included but were not limited to: policies and procedures, assessment tools, training records, program evaluations, meeting minutes, investigation records and employee files.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Residents' Council

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
6 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. 6. (11)	CO #001	2017_543561_0004	561

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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #023 had a plan of care indicating that they were at risk for falls and had a number of interventions in place to prevent them from falling. One of the interventions included in the plan of care was to ensure a level of supervision related to falls. Resident was also using bed rails while in bed.
On an identified day during inspection, LTCH Inspector observed resident was not provided the level of supervision as required as confirmed by Registered Staff #101. The PSW who provided direct care to the resident was aware of the interventions in place for the resident when interviewed. That same day LTCH Inspector went back to resident's room, resident was in bed and only one bed rail was applied. PSW #108, confirmed that resident required two bed rails.
The ADOC #001 was interviewed and confirmed that the PSW was aware of the interventions in place; however, still did not follow the plan of care.

B) On an identified date during this inspection, LTCH Inspector observed a device in a resident #028's room. Resident #028 was in bed and the device was not attached appropriately. There was no staff member present. RN #109 was at the nursing station and LTCH Inspector together with the RN went to resident's room. Resident was in bed and could not recall how they were transferred. The RN confirmed that resident's plan of care indicated that they required to have the device in place and the staff were to ensure it was attached appropriately and

functioning. Interviewed the PSW #110 who provided direct care to the resident and indicated that resident required the device.

The written plan of care was reviewed and indicated that staff were to ensure that the device was in place and to ensure that PSW staff check that the device was working on every shift.

Interviewed the ADOC #001 and indicated that resident #028 required to have the device. The ADOC stated that they audit all the equipment in the home and the latest audit completed on August 23, 2017 indicated that resident had a device in place. The ADOC confirmed that the plan of care was not followed.

The licensee failed to ensure that the care set out in the plans of care was provided to residents #023 and #028 as specified in the plans related to falls interventions. [s. 6. (7)]

2. The licensee failed to ensure that the resident that was reassessed the plan of care was 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.

Resident #028 had a written plan of care indicating that they had a condition and were on isolation with the Personal Protective Equipment (PPE) available at the door.
Resident was observed on an identified date during inspection and there was no signage at the door or PPE present. Progress notes were reviewed and indicated that on an identified date prior to this observation, resident no longer had the condition and treatment was completed. Progress note stated that resident was resolved from line listing.

Registered staff #109 was interviewed and confirmed that resident no longer had the condition and they completed treatment. The registered staff indicated that it was the staff's responsibility who resolved the resident from line listing to revise the care plan and confirmed that it was not done when resident’s condition had changed.

The licensee failed to ensure that the plan of care was revised when the care needs changed for resident #028. [s. 6. (10) (b)]

Additional Required Actions:

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

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

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.

In accordance with Ontario Regulation (O. Reg) 79/10, r. 48. (1) requires every licensee of a long term care home to ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's policy titled "Falls Prevention", policy number VII-G-30.00, revised on January 2015, instructed the registered staff to initiate a head injury routine if resident's fall was un-witnessed and to complete an electronic post fall assessment by using the Post Fall Huddle or Fall incident report, complete a thorough investigation of fall incident including all contributing factors and that the POA will be notified.

A Critical Incident System (CIS) was submitted to the Director with an allegation of a registered staff failing to assess resident #022 post falls that occurred on two shifts, in 2017. Registered staff #100 was interviewed and stated that resident sustained only one fall during their shift. Resident's clinical records were reviewed along with the investigation notes and indicated that the Head Injury Routine (HIR) was not initiated after the fall and registered staff did confirm that they did not witness resident falling, resident was already on the floor when they first observed them from the nursing station. The thorough investigation of the fall incident was not completed by the nurse and the Substitute Decision Maker (SDM) was not made aware of the resident sustaining the fall. The registered staff did confirm that none of the above were completed.
The interview with the DOC and ADOC #001 confirmed that the staff did not follow the home's Falls Prevention policy.

The above non-compliance was identified during a CIS inspection log number 006879-17. [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 used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Observations on an identified date in 2017, revealed bath chairs in two of the spa rooms did not have safety belts on them. PSW #118 and #119 confirmed residents were bathed using the chairs without safety belts, and did not know where the safety belts were located. Registered staff #112 confirmed residents were bathed using the bath chairs without safety belts, and further confirmed the chairs should have the belts on them to secure the residents while bathing. In an interview, PSW #120 confirmed the bath chair was used to bathe residents without the safety belt, and they further stated they did not know where the safety belt was located.

A review of policy titled "Bathing Transfer Devices", policy number VII-G-20.20(k), dated January 2016, directed staff to ensure the safety belt was kept in place during the entire bathing process as per manufacturer's instructions, including during transfer into the tub, bathing in the tub, and transferring out of the tub prior to being clothed.

A review of the "Arjo" manufacturer's instruction manual indicated the safety belt should be attached before the resident sat in the chair, and to ensure the resident was positioned correctly and the safety belt secured.

In interviews, the DOC and ADOC confirmed not all of the bath chairs in use for bathing residents had safety belts on them and confirmed the staff should not use the bath chairs unless they had a safety belt.

The licensee failed to ensure that the equipment in the home was used in accordance with manufacturers' 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 use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A Critical Incident System (CIS) was submitted to the Director with an allegation of a registered staff failing to assess resident #022 post two falls that occurred on two shifts, in 2017. Registered staff #100 was interviewed and stated that resident sustained only one fall during their shift. Registered staff indicated that resident was observed to have a responsive behaviour, sustained a fall and due to the behaviour registered staff were not able to fully assess the resident. The clinical records were reviewed and there was no documentation found in resident's clinical record about resident's condition on that shift. Registered staff did admit during the interview that they should have documented resident's condition and change in behaviour throughout the shift. On the following shift, once the home was made aware of the fall they assessed the resident and resident sustained multiple skin alteration. Resident continued to feel unwell and was sent out to the hospital for assessment and was diagnosed with a medical condition.
The DOC and ADOC #001 confirmed that the registered staff failed to document the change in resident's condition and failed to document the post fall assessment.

The licensee failed to ensure that the resident assessment and their responses to interventions were documented.

The above non-compliance was identified during a CIS inspection log number 006879-17. [s. 30. (2)]

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 actions taken with respect to a resident under a program, including assessments, reassessments, interventions and 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, the resident was assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident System (CIS) was submitted to the Director with an allegation of a registered staff failing to assess resident #022 post falls that occurred on two shifts, in 2017. The investigation notes indicated that Registered staff #100 failed to assess the resident post falls. Registered staff indicated during the interview that resident had responsive behaviour and they were not able to fully assess the resident; however, they did assess the resident for injuries. The health care records were reviewed and no post fall assessment could be found. Registered staff #100 confirmed that they did not complete the post fall assessment. The investigation notes also confirmed that the registered staff failed to assess the resident post fall. The interview with the DOC and ADOC #001 confirmed that the resident was not assessed using a post-fall assessment that was a clinically appropriate assessment instrument designed for falls after resident fell.

The licensee failed to ensure that the resident was assessed post fall using a clinically appropriate assessment instrument specifically designed for falls.

The above non-compliance was identified during a CIS inspection log number 006879-17. [s. 49. (2)]

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 when the resident has fallen, the resident is assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy under section 29 of the Act dealt with, (a) use of physical devices; and (d) types of physical devices permitted to be used.

A review of the home's policy, #VII-E-10.00(d), titled "Definitions, Types, and Considerations for Use of Restraint", dated January 2015, included under the heading "Physical Restraints": tabletops on chairs in place, lap belts, and bed rails only and did not include another device seen in the home. A review of the home's policy, #VII-E-10.00, titled "Personal Assistance Service Devices (PASD's)", last revised November 2015, did not include the use of all possible devices seen in the home.

Observations by inspector #591 revealed an identified resident, who was in a device that they were not able to get out of.
In interviews, registered staff #102 and PSW #103 confirmed resident was in a device that they could not get out of, as a safety consideration and the prevent an activity. Both staff identified the device used by this resident as a Personal Assistance Services Device (PASD) for comfort and positioning.

In an interview, the DOC confirmed the device was not identified in the home's minimizing of restraints policy as a physical restraint, or a PASD. [s. 109.]

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 home's written policy under section 29 of the Act deals with,
(a) use of physical devices; and (f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that had been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident was released from the physical device and repositioned at least once every two hours.
5. That the resident was released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Observations on identified date in 2017, revealed resident #004 was seated in a wheel chair in an identified location. The wheel chair was place in a way that prevented the resident from getting up. Resident was observed grabbing on to the bannister on the wall, trying to get up out of the chair. A device was attached to the chair. The resident could not be interviewed.

In interviews, registered staff #102 and PSW #103 indicated resident #004 was under observation, a device was used and the wheel chair was placed in a way that prevented them from getting up and/or falling out of the chair. The staff confirmed the resident was able to get out of the chair, therefore the above mentioned interventions were implemented to prevent the resident from sustaining injury. Both staff identified the use of the wheel chair as a Personal Assistance Services Device (PASD).

A review of the home's policy #VII-E-10.00(d), titled "Definitions, Types, and Considerations for Use of Restraint", dated January 2015, defined a restraint as any device or action that interfered with a resident's ability to make a decision or

which restricted their freedom of movement; any device would be classified as a restraint unless the resident was able to cognitively understand the purpose of the device and was able to release the device.

A review of the home's policy #VII-E-10.00(a), titled "Restraints – Guiding Us to Decide", dated January 2015, directed staff to ask certain questions to determine whether the device in use was a restraint or not. The first question for staff to consider was whether the intent of the device was to keep the resident in their bed or chair, and if the answer was yes, the second question was the ability of the resident to undo the device. Lastly, if the resident could not undo the device, the document indicated that the device was considered a restraint. The document then provided direction to the registered staff once the device was determined to be a physical restraint: initiate an interdisciplinary care team discussion, obtain power of attorney (POA) or resident consent, obtain a physician order, initiate PSW checks, and supporting documentation as outlined in the policy.

A review of resident #004's clinical health records did not include evidence that the use of the wheel chair had been ordered or approved by a physician or registered nurse in the extended class.

A review of resident #004's current written plan of care identified the use of the wheel chair as a PASD for comfort and positioning. It did not identify the restraining qualities of the use of the wheel chair in relation to the resident, as described by the staff, and observed by LTCH Inspector #591. A review of resident #004's most recent Resident Assessment Instrument - Minimum Data Set (RAI MDS) quarterly assessment, did not identify the use of a restraint. A review of assessments titled "Restraint/PASD Assessment", identified the use of the wheel chair used by resident #004 was a PASD for comfort and to relieve pressure.
In interviews, the DOC and Physiotherapist confirmed the the use of the wheel chair for resident #004 was assessed as a PASD and not as a restraint.

The home failed to ensure that the previously mentioned requirements were met when resident #004 was being restrained by a physical device under section 31 of the Act. [s. 110. (2)]

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 requirements are met where a resident was being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

4. That the resident is released from the physical device and repositioned at least once every two hours.

5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.

6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled "Prevention of Abuse and Neglect of a Resident", policy number VII-G-10.00, revised January 2015, indicated that all employees are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC and the Executive Director/Administrator or designate in charge of the home.

A Critical Incident System (CIS) report related to alleged neglect of a PSW towards a resident was submitted to the Director on an identified date in 2017. After reviewing the CIS report it was noted that the home became aware of the alleged neglect on a different date in 2017. The DOC was interviewed and they confirmed that the incident was reported late because the investigation was still underway.

The licensee failed to ensure that they were in compliance with their written policy that promotes zero tolerance of abuse and neglect.

The above non-compliance was identified while inspecting CIS log number 006879 -17. [s. 20. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Upon review of the Resident Council meeting minutes for year 2017, it was noted that the licensee did not always respond in writing within 10 days of receiving council's advice related to concerns and recommendations.
On July 19, 2017, concerns were raised by the Resident Council related to non-functioning ceiling lift, ripped privacy curtain and water temperature in a shower room. These concerns were added to the Residents' Council Meeting Follow Up Action Form. The meeting follow up action form showed the dates of when the items were resolved and looked at and all were resolved within 10 days; however, the written response was not provided to the council within 10 days. The department head signed this form on August 3, 2017 and the ED signed the form on August 9, 2017. The Director of Programs who was the assistant to the Resident Council indicated that the form was shown to the Resident Council after the ED signed the form.

The licensee failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns. [s. 57. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies.

Inspection of a medication cart on the fourth floor revealed six pairs of residents' glasses were stored in the cart.
In interviews, registered staff #113 and #114 confirmed the glasses were kept in the cart for safe-keeping for the residents.
In interviews, the DOC and ADOC confirmed non-drug related items were stored in the medication carts.

The licensee failed to ensure that drugs were stored in a medication cart that was exclusively used for drugs. [s. 129. (1) (a)]

Issued on this 1 day of February 2018 (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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

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

Inspection No. / No de l'inspection : 2017_543561_0015 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 023982-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 01, 2018;(A1)

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

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

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_543561_0004, CO #002;

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 :

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee shall do the following:
1. Ensure that the care set out in the plan of care is provided to residents as specified in the plan in relation to falls prevention.
2. Develop and implement an auditing process to improve and ensure compliance with following the plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10.

The non-compliance was issued as a compliance order (CO) due to a severity level of 2 (minimum harm/risk or potential for actual harm/risk) a scope of 2 (pattern) and a compliance history of 4 (ongoing non-compliance with a VPC or CO). A CO was issued under the same section on June 26, 2017 with a compliance date of September 15, 2017. Previously, a VPC was issued under the same section during a 2016 RQI, during a complaint inspection in May 2015 and a separate complaint inspection in June 2015.

A) During the previous inspection when the CO order related to s. 6(7) was issued on June 26, 2017, it was identified that staff did not provide care to two residents as specified in their plans of care. Those residents had interventions for falls that were either not functioning or were not applied as specified in the plan. Those two residents fell and sustained injuries.

B) During this inspection, LTCH Inspector reviewed two residents that were at risk for falls and found the home to be in non compliance with not following plans of care in relation to falls.

i) Resident #023 had a plan of care indicating that they were at risk for falls and had a number of interventions in place to prevent them from falling. One of the interventions included in the plan of care was to ensure a level of supervision related to falls. Resident was also using bed rails while in bed.
On an identified day during inspection, LTCH Inspector observed resident was not provided the level of supervision as required as confirmed by Registered Staff #101. The PSW who provided direct care to the resident was aware of the interventions in place for the resident when interviewed. That same day LTCH Inspector went back to resident's room, resident was in bed and only one bed rail was applied. PSW #108, confirmed that resident required two bed rails.
The ADOC #001 was interviewed and confirmed that the PSW was aware of the interventions in place; however, still did not follow the plan of care.

ii) On an identified date during this inspection, LTCH Inspector observed a device in a resident #028's room. Resident #028 was in bed and the device was not attached appropriately. There was no staff member present. RN #109 was at the nursing station and LTCH Inspector together with the RN went to resident's room. Resident was in bed and could not recall how they were transferred. The RN confirmed that resident's plan of care indicated that they required to have the device in place and

the staff were to ensure it was attached appropriately and functioning. Interviewed the PSW #110 who provided direct care to the resident and indicated that resident required the device.
The written plan of care was reviewed and indicated that staff were to ensure that the device was in place and to ensure that PSW staff check that the device was working on every shift.
Interviewed the ADOC #001 and indicated that resident #028 required to have the device. The ADOC stated that they audit all the equipment in the home and the latest audit completed on August 23, 2017 indicated that resident had a device in place. The ADOC confirmed that the plan of care was not followed.

The licensee failed to ensure that the care set out in the plans of care was provided to residents #023 and #028 as specified in the plans related to falls interventions. (561)

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

Feb 28, 2018(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, commercial courier 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, 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

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 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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

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 1 day of February 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Hamilton