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 sous la Loi de 2007 sur 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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 18, 2018	2018_650565_0007	010488-18	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

MATTHEW CHIU (565), DEREGE GEDA (645), IVY LAM (646)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 24, 25, 28, 29, 31, June 1, 4, 5, 6, 7, 8, 11, 12, and 13, 2018.

During this inspection, the follow up to order CO #001 related to resident plan of care was inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Director of Programs, Director of Environmental Services, Nurse Manager, Resident Assessment Instrument Minimum Data Set Coordinator, Residents Relations Coordinator, Staffing Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping Aides, Dietary Aides, Environmental Staff, Physiotherapy Assistant, Residents, and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_543561_0015	645

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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the outcomes of the care set out in the plan of care were documented.

The identified Inspection Protocol (IP) was initiated related to resident #013’s specified medical condition revealed in stage one of the Resident Quality Inspection (RQI). A review of the resident's clinical record showed resident #013 had the specified medical condition on an identified date, and a specified assessment was completed for the resident.

The resident's clinical record indicated they had a specified treatment continuing to be done at the time of this inspection. The outcomes of the specified treatment were documented using specified assessment parameters in a specified assessment tool, and the outcomes were documented on an identified date. The specified assessment tools for subsequent three consecutive weeks indicated only one of the above mentioned specified assessment parameters were documented.

Further review of the resident’s records did not reveal any other outcomes documented regarding the treatment of the resident’s specified medical condition during the identified period.

Observation of resident #013 on an identified date, with Registered Nurse (RN) #122 showed that resident #013 continued to receive the specified treatment, and RN #122 stated that the resident’s specified medical condition is still present.

RN #122 stated in an interview that if residents acquire the specified medical condition, registered staff should complete the above mentioned specified assessment tool on a weekly basis. They further detailed that completing the specified assessment tool included assessing and describing the specified medical condition, and documenting the outcome of the treatment by recording the above mentioned assessment parameters. RN #122 stated that registered staff did not document on the specified assessment tools for resident #013 during the three identified consecutive weeks as they should have.

Nurse Manager (NM) #117 and the Director of Care (DOC) stated the expectation was that registered staff should complete the above mentioned specified assessment tool for residents with the specified medical condition. The completion of the specified assessment tool includes detailing the measurement of the specified assessment parameters and document the outcome of the treatment, but it was not done for the identified period for resident #013. [s. 6. (9) 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 outcomes of the care set out in the plan of care are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they were not being supervised by staff.

On the initial tour of the home on May 24, 2018, at approximately 0930 hours, inspector #565 observed the following doors were equipped with keypad locks, closed, but not locked:
- Utility rooms across from rooms #115, #214, #315, and
- Tub room across from room #108.
During the above observation, there was no staff supervising the utility room across from room #115.

On May 31, 2018, at approximately1000 hours, inspector #645 observed the following doors were closed but not locked.
- Two tub rooms across from rooms #230, and #430,

- Housekeeping room across from room #216,
- Soiled utility room across from room #215,
- Dirty utility door in front of room #321, and
- Utility room in front of room #315.

During the above observation, residents were ambulating in the areas and staff were not observed in close proximity. All the doors are equipped with mechanical keypad locking mechanisms but they were not locked. Both the dirty utility and linen rooms' doors have signs specifying "Authorized Personnel Only", and allowing access to staff members only. Inspector #645 were able to open the above mentioned doors without entering the codes.

An interview with Registered Practical Nurse (RPN) #103 confirmed that the linen room on the second floor was unlocked. RPN #105 made several attempts to lock the door but failed. They indicated the door was supposed to be locked at all times to prevent residents from entering. They stated that they would send out a maintenance request to get the lock fixed.

An interview with Personal Support Worker (PSW) #107 and RN #108 confirmed that the linen and dirty utility rooms were not locked and accessible to residents. They both reiterated the expectation was that the above mentioned doors should be locked all the times to prevent residents from accessing them. They stated that they will send a maintenance request to have the door locks fixed.

An interview with the Director of Environmental Services (DES) and the Executive Director (ED) was conducted on May 31, 2018. During the interview, the DES acknowledged that the above mentioned doors were not locked and accessible to residents. They reiterated that the doors were expected to be locked at all times. [s. 9. (1) 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 all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they were not being supervised by staff, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's vision.

An identified IP was initiated for resident #001 related to prevalence of lack of identified action as revealed by the Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment during the RQI.

Review of the RAI-MDS assessment and Resident Assessment Protocols (RAPs) showed resident #001 had a specified visual condition with lack of the identified action. Care planning objectives were not indicated in the RAPs.

Review of the resident’s plan of care revealed it did not include a vision focus or interventions specific to the resident’s vision. Review of resident #001's assessment records did not reveal any assessment of the resident's vision.

Observations of the resident on an identified date revealed the resident was seated at the back of an identified home area, and an identified object was on the other end of the area. The resident was not able to respond to the inspector whether or not they were able to see the identified object. [s. 26. (3) 4.]

2. An identified IP was initiated for resident #013 related to prevalence of lack of identified action as revealed by the RAI-MDS assessment during the RQI.

Review of the RAI-MDS assessment and RAPs records indicated resident #013 had a specified visual condition with lack of the identified action.

Review of resident #013’s plan of care indicated it did not include a vision focus or interventions specific to the resident’s vision.

Interviews with RN #122, RAI-MDS Coordinator #104, and the DOC determined that the home’s interdisciplinary assessment of residents’ vision included the identified assessments, and that residents #001 and #013’s plans of care were not based on the interdisciplinary assessments of the residents' vision. [s. 26. (3) 4.]

Issued on this 5th day of September, 2018

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

Original report signed by the inspector.