Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 27, 2021	2021_526645_0006	004827-20, 012145-20, 021171-20, 021172-20, 000466-21, 001388-21, 001587-21, 001921-21	Critical Incident System

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

DEREGE GEDA (645)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 8, 9, 10, 11, 16, 17, 18, 19, 22, 23, 24, 25, and 26, 2021.

This inspection was completed to inspect upon the following intake logs:
- **#001388-21- related to fall prevention and management,**
- **#000466-21- related to fall prevention and management,**
- **#001921-21- related to prevention of abuse and neglect; and**
- **#012145-20- related to prevention of abuse and neglect.**

The following four Follow Up inspection logs, #001587-21, #021172-20, #021171-20, and #004827-20, were also inspected within this critical incident inspection.

One Voluntary Plan of Correction (VPC) under s.5, Safe and Secure Home, identified in a concurrent complaint inspection #2021_526645_0007 (Log # 003304-21), is issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Directors of Care (ADOC), Office Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector observed the provision of care, services and supplies; reviewed records including but not limited to relevant training records, compliance plans, the home's policies and procedures, residents' clinical health records, schedules and the home's investigative notes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

- **5 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. 15. (2)	CO #001	2020_659189_0006	645
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2020_526645_0006	645
O.Reg 79/10 s. 229. (4)	CO #001	2020_556168_0013	645
O.Reg 79/10 s. 8. (1)	CO #002	2020_556168_0013	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	Légende 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for residents.

Anonymous complaint was received by the Ministry of Long-Term Care (MLTC) indicating RN #100 abandoned residents; left the home prior to when the oncoming night nurse arrived on the unit; and did not complete the required transfer of accountability (TOA). The complainant reported that the residents on the unit required supervision as some residents were disoriented.

The home's investigation notes indicated that the RN left the building without completing TOA to the oncoming nurse, and residents were left unsupervised for over an hour. The RN was disciplined, and training was provided.

RPN #101 indicated that they did not receive TOA one hour into their shift and reported the incident to the clinical supervisor. The clinical supervisor contacted the RN and asked them to return to the home to complete the required TOA. RN #100 indicated that they left the home as there was no oncoming registered staff on the unit due to a scheduling error.

The DOC indicated that it was the expectation of the home and the College of Nurses of Ontario that registered staff complete TOA. They reiterated that TOA is essential for the safety and well-being of residents.

Sources: anonymous complaint report, and interviews with RN and the DOC. [s. 5.]

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 was protected from abuse.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 “Verbal abuse” means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A Critical Incident System(CIS) report was submitted to the Ministry of Long-Term Care (MLTC) regarding an alleged incident of abuse. The report indicated that PSW #105 was aggressive and used vulgar language during care provision.

The home investigated the incident and determined the PSW’s behaviour as verbal abuse; disciplinary measures were taken and training provided.

PSW #105 confirmed that they used inappropriate and vulgar language on the day. The PSW regretted the incident, and indicated that they were frustrated with the heavy workload at the home and lost their temper.

Inspector #645 reviewed two additional incidents to increase the incident sample size due to identified noncompliance. No noncompliance was identified in the expanded sample.

The DOC indicated that it was the expectation of the home that staff members communicate with residents in a respectful manner. The PSW used unprofessional and profane language, and jeopardized the safety and well being of resident #003. They indicated that the staff member was disciplined, and training was provided.

Sources: the home's investigation records, interviews with PSW #105 and the DOC. [s. 19. (1)]

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 residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: 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. (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 has failed to ensure that resident #002's plan of care was revised and updated when the resident's care needs changed.

A CIS report was submitted to the MLTC related to an incident that had caused an injury to resident #002.

The plan of care indicated that resident #002 required an identified type of device for mobility. On two occasions, Inspector #645 observed the resident not using the mobility device for ambulation.

PSW #102 and RN #103 indicated that the resident does not use the identified device for mobility as their health condition had improved. RN #103 indicated that the resident recovered from their previous health condition, and did not require the mobility device. The RN indicated that they will revise and update the resident's plan of care.

The DOC indicated that it was the expectation of the home that registered staff revise and update the resident's plan of care when their health condition changes.

Sources: observations, resident #002's plan of care and staff interviews. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated, such as abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations.

A CIS report was submitted to the MLTC regarding an alleged improper/incompetent treatment of resident #004 by staff members. The report indicated that the alleged incident occurred in September 2017 and the MLTC was notified three years later, in June 2020.

The home’s records indicated that the incident was not investigated in 2017. There were no records or staff interviews available.

The DOC indicated that the home did not investigate the allegation of abuse in September 2017 and there was no documentation available. They reiterated that it was the expectation of the home that every alleged incident of abuse and neglect, and improper/incompetent treatment of a resident was investigated.

Sources: CIS report and interview with the DOC. [s. 23. (1) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an alleged improper or incompetent treatment and neglect of resident #004, was reported to the MLTC immediately.

A CIS report was submitted to the MLTC regarding an alleged improper/incompetent treatment of resident #004 by staff members. The report indicated that the alleged incident occurred in September 2017 and the MLTC was notified three years later, in June 2020.

The progress notes on an identified date indicated that resident #004 brought a concern to RN #106 alleging a PSW was aggressive during care and made an inappropriate comment. The note indicated that the RN notified the management team on the same day.

Inspector #645 reviewed the Long-Term Care Homes.net reporting website and was unable to locate a mandatory critical incident report submitted by the home, regarding the alleged improper or incompetent treatment and neglect of resident #004.

During the interview, the DOC confirmed that this incident was not reported to MLTC immediately.

Sources: CIS report, progress notes and interview with the DOC. [s. 24. (1)]

Issued on this 6th day of June, 2021

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

Original report signed by the inspector.