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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 06, 2022	2021_766500_0029 (A1)	018632-21	Proactive Compliance 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

Amended by JOY IERACI (665) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): November 22, 23, 24, 25, 26, 29, 30, December 1, and 2, 3 (off-site), 2021.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOCs), Director of Environmental Services (DES), Director of Dietary Services (DDS), Director of Resident Programs, Team Member Coordinator, Scheduling Coordinator, Food Service Supervisor (FSS), Maintenance, Registered Nursing Staff, Personal Support Workers (PSWs), Dietary Aide, Housekeeping Staff, President of the Residents' Council and Family Council, Residents and Family Members.

During the course of the inspection, the inspectors observed meal service, medication administration, Infection Prevention and Control (IPAC) Practices, Residents' care areas, and reviewed residents' and home's records and pertinent home policies.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **0 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	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. 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #005, #010 and #033 as specified in the plan.

Resident #005 and #010 had physician orders for an identified medication. The orders had additional direction from pharmacy.

During medication administration observations on two identified days, by

inspector #665, Registered Practical Nurse (RPN) #119 and #120 did not follow additional direction from the pharmacy during medication administration for resident #005 and #010.

RPN #119 and #120 reviewed the resident's identified medication orders in the electronic medication administration record (e-MAR) and confirmed the direction.

Associate Director of Care (ADOC) #106 verified that RPN #119 and #120 did not follow resident #005 and #010's plan of care when the identified medications were administered.

Sources: Review of resident #005 #010’s physician orders, e-MAR, medication administration observations, and interviews with RPN #119, #120, ADOC #106 and other staff. [s. 6. (7)]

2. Resident #033's care plan indicated they required extensive physical assistance by two staff for an identified care related activity of daily living.

During an observation conducted by inspector #665, on an identified day, Personal Support Worker (PSW) #128 did not have a second staff with them while providing assistance with an identified care related activity of daily living and performed the identified care on their own,
PSW #128 indicated that two staff were required to provide assistance with an identified care related activity of daily living for resident #033. They confirmed that they did not follow the plan of care for the resident.

ADOC #124 agreed that PSW #128 did not follow resident #033's plan of care.

Sources: Review of resident #033's clinical records, observation on an identified day, interviews with PSW #128 and ADOC #124. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, 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 the Individual Monitored Medication Record and Shift Change Monitored Drug Count policies, included in the Medication Management System were complied with, for resident #006.

O. Reg. 79/10, s. 114 (2) requires that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the home's policies, "Individual Monitored Medication Record", dated January 2018 and "Shift Change Monitored Drug Count", dated November 2018.

Resident #006 had a physician's order for an identified medication. The identified medication was scheduled for two specified times in the morning and evening.

During a medication administration observation on an identified day, by inspector #665, with RN #114, there was a discrepancy in number of the identified

medication in resident #006's blister pack, with what was documented in the resident's Individual Monitored Medication Record, and the Shift Change Monitored Medication Count sheet.

The Individual Monitored Medication Record policy required that registered staff sign the record each time a dose was administered and document the new quantity remaining.

On the previous day, RN #127 did not sign the record when they administered the resident's evening dose of the medication, which caused the discrepancy on second day during the morning administration.

The Shift Change Monitored Drug Count policy indicated that the shift count must be reconciled with the amount of drug in the packaging, and with the Individual Monitored Medication Record. The policy required that the shift counts were done by two staff (leaving and arriving). Together, the two staff were to count the quantity of medications remaining, and confirm the quantity is the same as the amount recorded on the Individual Monitored Medication Record.

RN #127 told the inspector that they did not count together with the outgoing registered staff when the shift count was completed during the previous day at evening time. The RN indicated that they were busy, provided report to the staff and the outgoing registered staff did not mention there were any discrepancies in the count.

RN #114 indicated they conducted the shift count together with the outgoing registered staff on the second day at morning time. The RN told the inspector that they identified the discrepancy between the amount of an identified medication and what was documented in the Shift Change Monitored Medication Count sheet, and the Individual Monitored Medication Record, and told the outgoing nurse. The RN verified that they signed the shift count sheet without reconciling the amount of the identified medication present and what was documented.

ADOC #106 acknowledged that staff did not follow the home's "Shift Change Monitored Drug Count and Individual Monitored Medication Record" policies for resident #006.

Sources: Review of residents #005, #010 and #006's clinical records, Individual Monitored Medication Record Medical Pharmacy, Policy #6-5, Revised January

2018, Shift Change Monitored Drug Count Medical Pharmacies Policy #6-6 Revised November 2018, Observation on an identified day, interviews with RNs #114 and #127, ADOC #106 and other staff. [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 the Individual Monitored Medication Record and Shift Change Monitored Drug Count policies, included in the Medication Management System are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was on at all times for residents #004 and #001.

Interviews with PSWs #105, #103 and ADOC #106 indicated that when resident call bells were activated, a sound would be heard in the hallway of the resident home area and the light above the resident's entrance door would illuminate.

During the initial tour of the home on an identified day, by inspector #665 observations discovered that call bells were not functional in resident #004 and #001's rooms as follows:
1) Resident #004 - Sound was not heard in the hallway when the call bells by the resident's bed and washroom were activated and, the light did not turn on when the washroom call bell was activated and;
2) Resident #001's call bell did not have a button to activate the system.

ADOC #106 and PSW #103 verified that the call bells were not on at all times for residents #004 and #001.

Sources: Resident room observations on an identified day, and interviews with PSWs #105, #103, ADOC #106 and other staff. [s. 17. (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 the resident-staff communication and response system is on at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that staff and visitors participated in the implementation of the home's Infection Prevention and Control (IPAC) program for residents #007, #009 and #016.

During observations by Inspector #665, the following were observed:
1) Day A - Residents #007 and #009 had additional precaution signages indicating they were on Type X precautions;
2) Day A and B- Essential Caregiver (ECG) for resident #007 was providing direct care to the resident while using only one types of Personal Protective Equipment (PPE) on Day A, and two types of PPE on Day B, and;
3) Day B- Resident #016 had Type X precaution signage on their room door. PSW #121 was in the resident's room assisting the resident with a specified activity of daily living, wearing only one type of PPE.

RN #107 told the inspector that residents #007 and #009 were not on Type X precaution. Both residents were on Type Y precaution. The wrong signages were posted at the residents' door.

RPN #118 and RN #114 indicated that resident #007 was on Type Y precaution and four types of PPE were to be worn when direct care was provided. The staff confirmed that the ECG was not wearing the appropriate PPEs when they were providing direct care to the resident on Days A and B.

PSW #121 indicated that they were to use four types of PPE when they provided direct care to resident #016. The PSW acknowledged they were not wearing the appropriate PPE.

IPAC Lead #122 confirmed that staff failed to participate in the home's IPAC program for residents #007, #009 and #016.

Sources: Observations on November 24 and 30, 2021, review of from Public Health Ontario guidelines, and interviews with PSWs #115 and #121, RPN #118, RNs #114 and #107, IPAC Lead #122 and other staff. [s. 229. (4)]

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 staff and visitors participate in the implementation of the home's Infection Prevention and Control (IPAC) program., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded to the Family Council within 10 days of being advised of concerns or recommendations.

The president and assistant of the Family Council verified that the home was not always responding within 10 days of receiving the advice of concerns or recommendations from the Family Council.

Sources: Review of minutes of Family Council Meetings, Interviews with the President and Assistant of the Family Council. [s. 60. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement entered into in accordance with section 20 of the Local Health System Integration Act, 2006 or section 22 of the Connecting Care Act, 2019;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)

(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s policy to promote zero tolerance of abuse and neglect of residents was posted for the required information for the purpose of LTCHA s. 79 (1) and (2).

The inspector identified during the initial tour of the home on November 22, 2021, at 1040, 1110 hours, and on November 23, 2021, at 1003 hours, that the policy to promote zero tolerance of abuse and neglect was not posted in the home. On November 23, 2021, at 1120 hours, the Executive Director (ED) confirmed that the policy on zero tolerance of abuse neglect was posted on the home’s mandatory posting information board which was observed by the inspector at 1240 hours. The ED verified that the above-mentioned policy should be posted in the home.

Sources: Observations on November 22 and 23, 2021, Interview with ED. [s. 79. (3) (c)]

Issued on this 6 th day of January, 2022 (A1)

[redacted]

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

Original report signed by the inspector.