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 # / Registre no	Type of Inspection / Genre d'inspection
May 11, 2017	2017_547591_0003	018012-15, 032568-16, 034129-16, 034644-16, 001338-17	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Camilla Care Community
2250 HURONTARIO STREET MISSISSAUGA ON L5B 1M8

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

NATASHA JONES (591), DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

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

The purpose of this inspection was to conduct Complaint Inspections.

Concurrent Inquiries were completed during this inspection with the following log numbers:
034882-16 - resident's rights, responsive behaviours
001075-17 - medication, temperatures

Concurrent Critical Incident Inspections were completed during this inspection with the following log numbers:
006728-15, 022013-15, 029391-15, 029644-15, 032926-15, 002507-16, 004594-16, 005920-16, 008695-16, 012095-16, 019984-16, 021952-16, 031873-16, 035233-16, 002164-17.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Directors of Care (ADOCs), Social Worker (SW), Occupational Therapist, Physiotherapist, Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) Nurse, personal support workers (PSWs), BSO PSW, contracted service provider staff, residents and family members.

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

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Food Quality
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Skin and Wound Care

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

- **5 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	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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure if a resident was reassessed and the plan of care reviewed and revised because care set out in the plan had not been effective, ensure that different approaches were considered in the revision of the plan of care.

A review of resident #011's clinical health record revealed the resident had a specified number of falls between 2013 and 2016.
A review of a document titled "Falls Risk Assessment", dated February 2016, indicated resident #011 was "High Risk" for falls, and identified interventions were recommended and added to the resident's written plan of care. On a review of quarterly, consecutive written plans of care for the resident, the interventions were not revised although the resident continued to have falls. The interventions were revised in August 2016, related to falls prevention, and additional identified interventions were included. These interventions were implemented by the physiotherapist (PT) after their assessment in July 2016.

In an interview on March 1, 2017, the DOC indicated that at the time of resident #011's falls, it was not the home's practice to review each fall incident for interventions or strategies related to prevention. The PT who followed the resident until the summer of 2016, did not revise the interventions when they were not effective, however; the home had since made quality improvements to the falls program, and every fall was discussed in the falls huddles held monthly by the falls committee, to review and revise the plans of care related to falls as required for residents.

The home failed to ensure the plan of care related to falls for resident #011 was revised when the care set out had not been effective, and different approaches were not considered in the revision of the plan of care. [s. 6. (11) (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 if a resident is reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee failed to ensure residents received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

A complaint had been received by the Ministry of Health and Long Term Care (MOHLTC) Director from resident #011's substitute decision maker (SDM) which indicated the family had been providing specified care. They had been informed on the resident's admission to the home that care was a paid service, provided by a contracted service provider for a fee. The family later consented to and were billed for the paid service, which commenced in 2016.

In an interview in February 2017, resident #011's substitute decision maker (SDM) stated the resident did not appear to be getting designated care.
A review of the resident's clinical health record revealed the nurse from the contracted service provider documented they provided care to the resident on identified days in 2016.
In an interview in February 2017, PSW #107, who was the primary care provider for resident #011, stated they had never provided the specified care as the resident paid the

contracted service provider to provide the care, and prior to the contracted service provider providing the care, the resident's care was not provided by the staff.

A review of resident #011’s clinical health record revealed they did not have any disease or condition that contraindicated receipt of the specified care.
A review of the resident’s current written plan of care directed personal support workers (PSWs) to provide the specified care.
A review of a specified policy of the home directed registered nursing staff to refer residents to the staff of the contracted service provider as applicable, or if they were certified, to provide the specified care or refer to the physician or specified specialist for conditions outside of their scope of practice. PSW staff were directed to provide the specified care as scheduled unless it was contraindicated for the resident. The policy further directed the registered staff to ensure the care plan outlined who would provide the care.
A review of a document dated May 2016, directed PSW staff to check residents' as scheduled related to the specified care and provide the care, should there be interruption of service from the contracted service provider, and further directed them to continue to encourage families to sign consent for the contracted service provider for the specified care.

In interviews in February 2017, PSW #107, #108 and registered staff #105 stated the specified care was provided to the residents by the staff of the contracted service provider for a fee. The Director of Care (DOC) and ADOC stated the specified care was offered to residents or their SDMs on admission for a fee, however; if they did not consent, it was the home’s expectation that the PSWs would provide the care unless the care was contraindicated for the resident, which the care would then be provided by the registered staff. The DOC confirmed that the staff were expected to provide the specified care to all resident's unless they consented to the services of the contracted service provider for a fee.

The licensee failed to ensure resident #011 received the specified care. [s. 35. (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 residents receive preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. The licensee failed to ensure mobility devices, including wheelchairs, walkers and canes, were available at all times to residents who required them on a short-term basis.

A review of a document titled "Master Agreement", between Camilla Care Community and Home Mobility Equipment (HME) indicated the contractor agreed to provide loaner equipment as needed.

In an interview in February 2017, the physiotherapist (PT) stated they received a referral in July 2016, as resident #011 had a change of their condition. Specified equipment was being used related to their medical condition. The PT completed an assessment and sent a referral to the Occupational Therapist (OT) for an assessment related to the equipment. The PT stated they received another referral in the same month, after an incident had occurred. The staff were instructed by the PT to no longer use the specified equipment, and another referral was sent to the OT for another assessment. The PT stated a specified piece of equipment had been obtained for the resident to use, however; a referral was sent for an assessment to be completed to ensure it was safe prior to its use. The OT completed the assessment and deemed the specified equipment not safe for use.
In an interview in March 2017, the OT confirmed they completed an assessment for resident #011 and determined they needed a specified piece of equipment. The OT arranged for a loaner from the vendor while the resident waited for the specified equipment to arrive; however, the loaner did not arrive for several weeks. During this period, there was no equipment deemed safe for the resident to use.
In an interview in February 2017, registered staff #120 confirmed resident #011 remained in bed for a period of several weeks, while waiting for their specified equipment to arrive, because the home had no safe equipment for the resident to use, and the OT had not provided them with a loaner for the resident to use while waiting.

The home failed to ensure specified equipment was available on a short term basis for resident #011. [s. 39.]

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 mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee failed to ensure that residents were not charged for goods and services that a licensee was required to provide to residents using funding that the licensee

received from the Minister under section 90 of the Act.

A) In an interview in February 2017, resident #011's substitute decision maker (SDM) stated they had been advised by the home that specified care was only provided by a contracted service provider for a fee. Originally, the family had been providing the care, however, when they were no longer able, they consented to the contracted service provider to provide the care for a fee. They further stated the resident did not have any condition that contraindicated receiving the care. They stated they were not informed by the home that the specified care was to be provided to residents by staff of the home free of charge, unless contraindicated. A related assessment could not be located in their clinical health record.

B) In an interview in February 2017, resident #025 stated they paid for specified care to be provided by the contracted service provider. They stated they had been instructed by the home that this arrangement was required to receive the care, and further that they were not aware the care should be provided by the home free of charge unless contraindicated or upon request by the resident for services beyond the specified care. The resident stated they did not have any conditions that would contraindicated receiving the care. A review of the clinical health records for resident #025 revealed they did not have any condition that contraindicated receiving the care. A related assessment could not be located in their clinical health record.

C) In an interview in February 2017, resident #026 and their SDM stated they paid for specified care to be provided by the contracted service provider. They stated they had been instructed by the home that this arrangement was required to receive the care, and further that were not aware the care should be provided by the home free of charge unless contraindicated or upon request by the resident for services beyond the specified care. The resident and their SDM stated the resident did not have any conditions that would contraindicated receiving the care. A review of the clinical health records for resident #026 revealed they did not have any condition that contraindicated receiving the care. A related assessment could not be located in their clinical health record.

A review of resident #011's current written plan of care directed personal support workers (PSWs) to provide the specified care as scheduled. There was no mention of the care being provided by staff from the contracted service provider.

A review of resident #025 and #026's current written plans of care indicated the residents had consented for the specified care to be provided by the contracted service provider.

Resident #026's plan also included direction for PSW staff to provide the care.
A review of a document from an identified unit in the home revealed the following data: 33 residents in total, 22 paid for the contracted service provider to provide the specified care, seven had conditions which contraindicated receiving the care, and of those, two received the care from the contracted service provider.

In interviews in February 2017, PSW #107, #108 and registered staff #105 indicated that specified care was provided by staff from the contracted service provider for a fee. The Director of Care (DOC) and ADOC stated the specified care was offered to residents or their SDM on admission for a fee, however; if they did not provide consent, it was the home's expectation that the PSWs would provide the care unless contraindicated, as their care would be provided by registered staff.

In an interview in February 2017, the staff from the contracted service provider, stated on their visits to the home, the home provided them with a list of residents to see, and they provided the specified care for whomever consented and paid the fees. This was confirmed by the Client Care Manager of the contracted service provider in an interview in March 2017.

A review of the Service Agreement between the home and the contracted service provider, dated August 2016, indicated the specified care would be provided to residents who consented, as scheduled for a specified fee per visit. The DOC stated prior to the agreement, a similar agreement was in place with the previous service provider.

A review of a policy, revised January 2016, indicated the unfunded services included a charge to the resident if requested. The document also stated residents and/or their representatives would not be charged for any unfunded services provided to the resident.

The licensee failed to ensure residents were not charged for services that the home was required to provide using funding received from the Minister under section 90 of the Act. [s. 245. 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 residents are not charged for goods and services that a licensee is required to provide to residents using funding that the licensee receives from the Minister under section 90 of the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent. 2007, c. 8, s. 7.

Findings/Faits saillants :

1. The licensee failed to ensure they did not provide care or services to a resident without the resident's consent.

A) A complaint was reported to the MOHLTC Director in July 2015, by an identified individual known to resident #013.
In an interview in March 2017, the complainant indicated that at the time of discharge from the home, resident #013's family noted altered skin integrity of the resident, and noted there was a change in their plan of care for which they had not been informed of and had not consented to. The family believed the change in the resident's care plan contributed to a change in their medical condition.
A review of resident #013's clinical health record indicated the resident had an incident in the home which resulted in altered skin integrity, and documentation confirmed the family were notified. Record review confirmed treatment to the resident occurred as per the home's policies.
A review of the resident's care plan for a specified period during their admission, indicated there was a change in the plan, ordered by the home's physician on a specified date, and implemented for the resident as ordered. A review of the progress notes indicated the change in the care plan was a result of the resident's medical condition.
A review of the clinical health record revealed the resident was unable to consent to any

care or services. No documentation of a discussion with the family with regards to the change in the resident's plan nor consent from the substitute decision-maker on the resident's behalf could be located.
In an interview, the DOC confirmed consent was not obtained, but should have been when there was a change in resident #013' plan of care.

The home failed to ensure they obtained consent from the resident's SDM when there was a change in their plan of care. [s. 7.]

B) A complaint had been received by the MOHLTC Director from resident #011's SDM, who alleged the Occupational Therapist (OT) after completing an assessment of the resident, ordered specified equipment based on their medical condition but did not obtain prior consent.

In an interview in February 2017, the PT stated they received a referral in a specified month in 2016 that resident #011 had a change in their medical condition. The PT completed an assessment then made a referral to the OT to conduct an assessment for equipment.
In an interview in March 2017, the OT confirmed they had completed an assessment of resident #011 for specified equipment, and ordered the equipment without prior consent.
In an interview in March 2017, the DOC confirmed it was the OT's responsibility to assess residents for equipment, discuss their recommendations with the resident or their SDM and obtain consent prior to placing any order.

The home failed to ensure they obtained consent from resident #011's SDM prior to purchasing equipment. [s. 7.]

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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

Issued on this 18th day of May, 2017

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

Original report signed by the inspector.