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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 20, 21, 2019	2019_631210_0006	002534-19	Complaint

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

SLAVICA VUCKO (210)

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): March 8, 11, 12, 13, 14 and 15, 2019

During the course of the inspection, the following complaint intake intake was inspected:
-Intake log #002534-19 related to personal support services.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Director of Care (DOC), Physician, Clinical Consultant Pharmacist, Coroner, Behavioural Support Ontario (BSO) lead, and the complainant.

During the course of the inspection the inspector reviewed the clinical record of three residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to Ministry of Health and Long Term care (MOHLTC) on a specified date, by a family member. According to the complainant the resident was administered medication for which the SDM was not notified and therefore had not consented. The complainant further reported that the resident was not provided treatment as per their wish.

A review of resident #001's clinical record indicated they stayed in the home for a specified period of time, and had specific diagnosis. The family members were present during the admission. Two of the family members were the Substitute Decision Makers (SDM) for the resident.

Interview with resident's SDM #1 indicated during the admission they were involved in sharing resident's information with RN #103 and signing the required admission documents as requested. According to SDM #1 they became aware that resident #001 were administered a specific medication. SDM #1 indicated that resident #001 was not on this medication before the admission in the long term care (LTC) home. They were not aware that the resident was prescribed or administered the medication during their stay in the LTC home.

Interview with registered nurse (RN) #103 indicated they were involved in admitting resident #001 and reconciling the medications. After they called the physician to confirm the current medications and discussed the history of resident's diagnosis, the physician prescribed the specific medication as needed, for managing the resident's diagnosis. Further, RN #103 indicated they mentioned the new medication to the resident's family member, who was not the SDM, and was not able to confirm if SDM #1 or #2 provided an informative consent.

A review of resident #001's progress notes and electronic medication record (eMAR) indicated the specific medication was administered a specified number of times during their stay in the LTC home. The resident was on another similar medication for similar diagnosis but with prolonged reaction. This one was increased to double dose sometime in the midst of the stay in the LTC home. A third medication was prescribed for managing insomnia. According to the clinical record SDM #1 was informed about these changes.

Interview with RPN #107 indicated they discussed with resident #001's SDM #1 during several occasions about non-pharmaceutical interventions for managing the above mentioned diagnosis, but they never mentioned to them about the pharmacological intervention with the specific medication. RPN #107 indicated that the registered staff on the unit are supposed to discuss the pharmacological interventions with the family.

A review of the clinical record and interview with SDM #1 indicated that the PRN administration of the specific medication that was introduced at admission was not discussed with the SDM. Interview with RN #104 indicated they were not involved in discussing with the family about the option for a specific treatment in case of a medical emergency.

Interview with RN #105 indicated the forms that were not completed with the SDM by the admitting registered staff they were supposed to be completed by the following shift registered staff. One of the forms was for the above mentioned treatment in case of an emergency which gets filled out only when the SDM's choice is the specific treatment not to be initiated. RN #105 indicated they were under impression that resident #001's status was the specified treatment not to be initiated in case of an emergency but were not sure exactly where they received the information from.

A review of the admission package indicated resident #001 was in hospital before coming to the LTC home and the hospital report stated that a specific treatment not to be administered in a case of specific medical emergency. RN #105 intended to phone the SDM in regards to the mentioned specific treatment of the resident, but before confirming with them they filled out and signed the form for the specific treatment not to be administered. The form was filed in the resident's chart. Interview with the DOC indicated the direction from the hospital report about resident #001's specific treatment or non-treatment status should be clarified with the SDM at the time of admission.

A review of the above mentioned non-treatment form (issued by the governmental authorities) indicates a signature on the form that confirms a specified non-treatment status of the resident in case of a medical emergency. The signature section does not specify who to sign the form. The form further states that with respect to the named patient, that there are several conditions that must be met prior to implementing. Interview with DOC indicated the expectation is the form to be signed by registered nurse after discussion with the resident or their SDM and the outcome be documented in the resident's chart.

According to the clinical record, on a specified date and time, resident #001 completed the dinner and was still sitting at the dining table. Interview with PSW #102 indicated the resident walked to the dining room, ate independently and did not present with signs of distress during the dinner. According to RPN #101, a medication was administered after the dinner for a specific health condition. According to PSW #102, PSW #112 was present in the dining room when they helped another resident to their room. Residents finished eating and the plates were removed from the table. When PSW #102 arrived back to the dining room and approached resident #001 to take them to their room, they did not respond. Registered Practical Nurse (RPN) #101 was informed, and they identified that the resident in distress. According to RPN #101, two other registered nurses arrived at the scene. Ambulance was not called and a specific treatment was not initiated. The family was informed and arrived immediately. They queried if the specific treatment was initiated. The doctor on call was informed and came to the home.

A review of the progress notes and the Dementia Observation System (DOS) forms indicated the resident was administered the specific medication when they presented with a specific signs and symptoms.

Interview with resident #001's family physician indicated when new medications are prescribed to a resident the expectation is registered staff to inform and obtain a consent from the resident, if competent, or the SDM. Interview with DOC indicated when there is a change in the treatment of a resident who is incompetent, the SDM should be notified, a consent obtained and documented in the resident's chart. The same is expected to be performed at admission and when resident's SDM changes the decision for a specific type of treatment during medical emergency.
The DOC acknowledged that the above mentioned expectations when resident #001's new medication was initiated and the specific treatment status was determined were not performed accordingly. [s. 6. (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 resident, the SDM, if any, and the designate of the resident / SDM are given the opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 22nd day of March, 2019

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

Original report signed by the inspector.