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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 26, 2019	2019_766500_0007	027285-17, 000578-18, 002652-18, 003758-18, 004373-18, 008988-18, 014419-18, 016993-18, 028395-18, 032860-18, 033337-18	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

NITAL SHETH (500)

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, 11, 12, 13, 14, 15, 18, 2019.

The following intakes were inspected during this inspection:

008988-18, CIS #2472-000014-18 related to staff to resident abuse, 016993-18, CIS #2472-000022-18, 003758-18, CIS #2472-000009-18, related to resident to resident altercation, 028395-18, CIS #2472-000022-18, 032860-18, CIS #2472-000026-18, 033337-18, CIS #2472-000027-18, related to falls resulted in an injury.

The following intakes were completed during this inspection: 027285-17, CIS #2472-000021-17, 000578-18, CIS #2472-000002-18, 002652-18, CIS #2472-000007-18, 004373-18, CIS, #2472-000011-18, 014419-18, CIS #2472-000018-18 related to falls.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Residents.

During the course of the inspection, the inspector observed the residents' care areas, reviewed residents' health care records, staffing schedules, and home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the Critical Incident System (CIS) Report indicated an alleged physical abuse from staff to resident #006.

A review of the resident's written care plan indicated that the resident had a responsive behaviour during care. Staff were to talk to the resident in a calm and gentle voice, not to rush the resident, and to leave the resident at least 15 minutes and reapproach gently if the resident exhibits with responsive behaviour.

Interview with Personal Support Worker (PSW) #101 and PSW #102 indicated that on an identified day, the resident exhibited with responsive behavior towards them while providing personal care. Both PSWs confirmed that as per the plan of care, they should have left the resident's room and reapproached them for the care. PSW #101 and #102 confirmed that they are expected to follow the resident's plan of care.

During interviews, Registered Practical Nurses (RPNs) #103, #104 and the Director of Care (DOC) indicated that PSWs are expected to follow the resident's plan of care. [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 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 protect residents from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff.

For the purposes of the definition of physical abuse in subsection 2 (1) of the O. Reg. 79/10, "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain, and "verbal abuse" means any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self-worth made by anyone other than a resident. Verbal abuse also includes any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

A review of the CIS indicated on an identified day, staff notified the Assistant Director of Care (ADOC) about an alleged abuse from a co-worker to resident #006. The allegation indicated that the staff member hit resident #006 three which resulted in an injury. In addition, the staff member took a dirty towel and rubbed it to the resident's face in response to the resident's responsive behaviour during personal care.

A review of the resident's written care plan indicated that the resident exhibited with responsive behaviour during care. Staff were to talk to the resident in a calm and gentle voice, not to rush the resident, and to leave the resident at least 15 minutes and reapproach gently if the resident have behaviour.

A review of the email, sent by PSW #101 to the ADOC, indicated that PSW #101 reported that PSW #102 was being physically abusive to the resident when the resident exhibited with responsive behaviour during care.

The inspector was not able to interview the resident due to cognitive impairment.

A review of the home's investigation notes indicated that PSW #102 stated that PSW

#101 threatened the resident to call police while providing care to the resident. PSW #101 stated that PSW #102 hit the resident three times, causing an injury in the body area. The PSW then used a dirty towel and rubbed it onto the resident's face when the resident exhibited with responsive behaviour towards the PSWs.

An interview with PSW #101 indicated that they assisted PSW #102 to provide personal care on an identified day. It was the beginning of the shift, during their round, when they identified that resident #006 required personal care. PSW #102 and #101 decided to provide care to the resident. During care, the resident exhibited with responsive behaviour. PSW #101 indicated that in response to the resident's behaviour, PSW #102 hit them three times, where the resident started showing an injury to the body area. PSW #102 also used a soiled towel and rubbed it on the resident's face. PSW #101 indicated that they never seen something like this, being aware that it was not appropriate but could not report it immediately because they were feeling scared. PSW #101 also stated that PSW #102 threatened the resident that they would call police.

During an interview, PSW #102 denied hitting the resident, and accused PSW #101 of being verbally abusive and threatening the resident in a loud voice to call police.

Interview with the DOC confirmed that when the staff threatened to call the police on the resident it is considered as verbal abuse, however physical abuse was not identified. The DOC told the inspector that there was no negative outcome even though the resident had an injury to the identified area.

A review of the home's policy #VII-G-10.00, entitled, "Prevention of Abuse & Neglect of a Resident", revised December 2018, indicated that abuse and neglect are not tolerated in any circumstances by anyone.

This non-compliance is warranted based on PSW #101 witnessing and providing a consistent statement about PSW #102 being physically abusive to resident #006, and causing an injury to the resident's body area. The inspector also determined that verbal abuse occurred as the resident was threatened by staff to call police. [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 protect residents from abuse by anyone and shall ensure that residents were 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure without in any way restricting the generality of the duty provided for in section 19, that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A review of the CIS indicated on an identified day, staff notified the Assistant Director of Care (ADOC) about an alleged abuse from a co-worker to resident #006. The allegation indicated that the staff member hit resident #006 three which resulted in an injury. In addition, the staff member took a soiled towel and rubbed it to the resident's face in response to the resident's responsive behaviour during personal care.

Interview with PSW #101 indicated that they failed to immediately report the physical abuse of resident #006, as they were afraid to report it, however they felt guilty and therefore, it was reported later to the ADOC.

Interview with PSW #102 reported verbal abuse from PSW #101 to resident #006, and that they failed to immediately report it because the resident was fine after the care was provided.

A review of the home's policy #VII-G-10.00, entitled, "Prevention of Abuse & Neglect of a Resident", revised December 2018, indicated that if any team member witnesses an incident or has any knowledge of an incident that constitutes resident abuse or neglect, all team members are responsible to immediately inform the Executive Director (ED) and or charge nurse in the home.

Interview with the DOC indicated that the staff are required to immediately report any alleged abuse that they are aware of. [s. 20. (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 without in any way restricting the generality of the duty provided for in section 19, that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A review of the CIS indicated an alleged physical abuse from staff to resident #006.

A review of the CIS and interview with the DOC did not indicate the police had been notified of this incident. The DOC indicated that the police should have notified about the incident. [s. 98.]

Issued on this 28th day of March, 2019

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

Original report signed by the inspector.