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

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 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
Dec 23, 2020	2020_631210_0018	012670-20, 018290-20, 020974-20, 022139-20	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

SLAVICA VUCKO (210), HEATHER PRESTON (640)

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): November 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, and 26, 2020

During the course of the inspection the following Critical Incident System (CIS) reports were inspected:
-Intake #022139-20 (CIS #2472-000068-20) related to mandatory reporting;
-Intake #020974-20 (CIS #2472-000065-20) related to personal support services;
-Intake #018290-20 (CIS #2472-000054-20) related to hospitalization;
-Intake #012670-20 (CIS #2472-000020-20) related to unexpected death.

This inspection was conducted concurrently with complaint intake #016464-20 (Inspection report #2020_821640_0024) related to personal care services.

During the course of the inspection, the inspector(s) spoke with the interim Executive Director (ED), interim Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Physicians, Physiotherapist (PT), Representative from Mobile Imaging Company and Personal Support Workers (PSWs).

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Pain
Reporting and Complaints

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #050 so that their assessments were integrated, consistent with and complemented each other.

a) Resident #050 passed away unexpectedly on an identified date. Before the resident passed away, they reported to staff that they had some discomfort and requested to be treated. The registered staff did not treat the symptoms of discomfort as requested. RPN #108 was unavailable to be interviewed.

There was no documentation in progress notes about resident #050's symptoms. RN #100, who worked that day on the same unit, was not aware that resident #050 complained of discomfort, in order to further asses the resident.

b) Resident #050 received a medical test on an identified date, as ordered by the Physician. The lab result was faxed to the home the next day. The result stated that close follow-up was recommended. The registered staff, who worked on the day when the result was received, did not process it. The following day there was further worsening of resident #050's condition from their baseline. No further action was taken.

The Physician assessed the resident five days after the lab result was received at the home, during the regular weekly visit and prescribed a treatment. The Physician was informed five days after the abnormal lab results were received at the home.

Sources: CIS report, resident #050's clinical record (progress notes, Electronic Medication Administration record (eMAR), Physician's orders), interviews with registered nurses and other staff. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #050 passed away unexpectedly on an identified date. The resident was prescribed a medication for pain on scheduled basis every day and additional dosage to be administered as needed (PRN).

The Physician's order from an identified date, indicated the scheduled pain medication to be discontinued, and a second pain medication to be initiated. Further, the second pain medication was also prescribed on a PRN basis.

Staff did not comply with the home's Pain and Symptom Management policy when a pain assessment was not initiated to determine the resident's pain level and effectiveness of the pain medications.

Sources: resident #050's clinical record (eMAR, progress notes), Pain and Symptom Management policy, #VII-G-30.30 from April 2019, Physician's order, interview with registered nurses and other staff. [s. 52. (2)]

2. The sample for pain management was expanded with resident #051.

Resident #051 was receiving two scheduled medications for identified pain. According to the pain scale score documentation the pain score was four or more eight times during two months period.

One of the resident's medications for pain management to be administered on a PRN basis was increased in dosage. Three weeks later the same medication was changed to a scheduled administration. Over this same time period, one of the above scheduled pain medications was also increased in dosage.

Resident #051 was not assessed for pain using the tool in the pain assessment tab in the electronic documentation, when they exhibited pain of four or more out of 10 during a period of two months.

Sources: resident #051's clinical record (eMAR, progress notes), Pain and Symptom Management policy, #VII-G-30.30, dated April 2019, Physician's orders, interview with ADOC, interim DOC and interim ED. [s. 52. (2)]

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 when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death in the home, followed by the report required under subsection (4).

a) Resident #059 passed away unexpectedly on an identified date. On the dame day, the resident was walking around the unit. One hour before the resident died they presented with abnormal symptoms. The registered staff assessed the resident and administered a PRN medication to relieve the symptoms. Previously resident #059 did not present with expected signs and symptoms of dying and was not on end of life/palliative care. The unexpected death was not reported to the Director immediately.

Sources: CIS report, resident #059's clinical record, interview with interim DOC and interim ED.

b) Resident #050 passed away unexpectedly on an identified date. On the same day, the resident was able to function as per their usual daily routine. The resident had a chronic condition for which they were on continuous treatment. During the day the resident complained of some discomfort. A few hours later the resident was found unresponsive on their bed. The registered staff was notified, and further assessment was performed. The resident's death was pronounced by paramedics. Previously resident #050 did not present with expected signs and symptoms of dying and was not on end of life/palliative care. The unexpected death was not reported to the Director immediately.

Sources: CIS report, resident #050' clinical record (progress notes), interview with registered nurses and other staff. [s. 107. (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 that the Director was immediately informed, in as much detail as is possible in the circumstances, of an unexpected or sudden death in the home, followed by the report required under subsection (4), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #050 passed away unexpectedly on an identified date. The resident had a diagnosis of a chronic condition and was on continuous treatment of oxygen at identified dosage. They had prescribed medication to be administered as needed for shortness of breath (SOB).

During two occasions, the resident was administered more than the prescribed maximum dosage of oxygen for SOB. The medication was not administered on one occasion when the resident presented with SOB.

Resident #050 was not administered oxygen as per the physician’s order on two occasions, and the medication as needed for SOB was not administered on one occasion.

Sources: resident #050’s clinical record (progress notes, eMAR, Physician's orders), interview with registered nurses and other staff. [s. 131. (2)]

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

Issued on this 12th day of January, 2021

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

Original report signed by the inspector.