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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 24, 2020	2020_821640_0024	016464-20	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

HEATHER PRESTON (640)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 19, 20, 23 and 25, 2020.

NOTE: This inspection was conducted concurrently with inspection #2020_631210_0018.

The following Complaint inspection was reviewed:
Log #016464-20 related to concerns about care

During the course of the inspection, the Long-Term Care Homes (LTCH) Inspector toured the home, observed the provision of care, reviewed clinical records and policy/procedure and conducted interviews.

During the course of the inspection, the inspector(s) spoke with residents, substitute-decision makers (SDM), housekeepers, personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Associate Directors of Care (ADOC), the Acting Director of Care (DOC) and the Acting Executive Director (ED).

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Pain
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, they were assessed using a clinically appropriate post-fall assessment instrument that was specifically designed for falls.

A staff member found a resident on the floor and informed the registered staff immediately.

The clinical record was reviewed and there was no post-fall assessment conducted. There were no notes written by the nurse indicating the resident had fallen and the outcome of the fall. Two days later, staff noticed signs of injury and the resident was transferred to hospital.

Not conducting a post-fall assessment resulted in injuries not being identified and treated in a timely manner.

Sources: Complaint log, resident's clinical record, interview with the DOC and other staff. [s. 49. (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 residents have fallen, they are assessed using a clinically appropriate post-fall assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that an assessment of altered skin integrity was conducted for a resident using a clinically appropriate assessment instrument specifically designed for the assessment of skin.

i) PSWs reported to a registered staff that a resident had bruising, swelling and redness on a specific area.

The clinical record was reviewed and there were no skin assessments conducted using a clinically appropriate assessment instrument of the area.

There was a risk of unknown deterioration of the areas without the appropriate assessment and associated treatment.

ii) A resident returned from hospital with an area of altered skin integrity.

The clinical record was reviewed and there was no skin assessment conducted of the area using a clinically appropriate assessment instrument.

There was risk of infection and/or potential worsening of the area without assessment.

Sources: clinical record, assessment tab in PCC, interview with a registered staff, the DOC and others. [s. 50. (2) (b) (i)]

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 an assessment of altered skin integrity is conducted for residents using a clinically appropriate assessment instrument specifically designed for the assessment of skin, 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed within one business day of, Subject to subsection (3.1), an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Staff informed a nurse that a resident had redness, bruising, pain and swelling and could not walk. The resident was transferred to hospital for further assessment.

Upon return to the home the resident was assessed as having a significant change in condition.

The Director was not informed of the incident and the resultant change in the resident's condition.

Sources: ltchomes.net, clinical record, interview with the DOC and other staff. [s. 107. (3)]

Issued on this 22nd day of March, 2021

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

Original report signed by the inspector.