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 18, 2019	2019_654618_0010	012832-17, 023673-17, 000403-18, 001781-18, 015180-18, 025361-18	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

CECILIA FULTON (618)

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

The following complaint intakes were inspected during this inspection:
Log # 012832-17, related to plan of care, nutrition and hydration and residents rights.
Log # 023673-17, related to plan of care.
Logs #000403-18, 001781-18, 015180-18, 025361-18, all submitted by the same complainant and related to alleged abuse, dining service, residents rights, plan of care.

During the course of the inspection, the inspector(s) spoke with The Director of Care (DOC), The Assistant Director of Care (ADOC), Registered Nurse (RN), Physiotherapy (PT), Occupational Therapist (OT), Personal Support Worker (PSW), Residents and Residents Substitute Decision Makers (SDM).

During the course of the inspection, the inspector conducted record review, observed residents and staff to resident interaction.

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)**
- **0 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 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 complemented each other.

This inspection was initiated due to a complaint which identified that there was a considerable delay in implementing strategies to address resident #003's care needs.

Review of the resident's progress notes identified that on May 8, 2017, resident #003's SDM reported to RN #101 that the resident was experiencing pain in an identified area and the SDM requested a referral to an identified health care practitioner. RN #101 documented that they had put a the referral in as per the process. .

A progress note dated May 10, 2017, by RN #100 identified that they were aware of this issue and would send a referral to the identified health care practitioner if it has not been done yet.

The inspection did confirm that both of the above mentioned referrals had been documented on the required referral forms, on May 8 and 10 respectively, as per the home's process.

A progress note dated May 10, 2017, written by the PT, identified that they had received a referral and had assessed the resident and they documented that a referral to the identified health care practitioner had been made.

Review of resident #003's written progress notes did not include any further documentation regarding this issue until a note written on September 30, 2017.

A progress note dated October 11, 2017, written by RN #100, identified that a referral to an identified health car practitioner was being made for resident #003's to assess the resident for an identified issue.

Interview with RN #100 identified the referral process and that there is no process to follow up that the referral has been accepted or acted upon.

Interview with the PT identified that they make referrals to the identified health care practitioner if indicated, and they identified the process for making the referral, which was the same as referrals made by the registered staff. The PT identified that if a resident is not remaining on their PT caseload, they may not have follow up regarding the progress of the referral, and that they would rely on communication with the nursing staff.

Interview with DOC revealed that the home's former identified health care practitioner had stopped working for the home around May 2017. The home had identified problems with that practitioner, including absences and poor communication.

Interview with the current identified health care provider who assumed responsibilities later in May 2018, stated that they had not received a report from the departing provider and that they were not aware of any outstanding referrals for resident #003 when they started working here.

Interview with the DOC confirmed that there was lack of collaboration to confirm that referrals to the identified health care provider for resident #003 had been picked up and acted on. [s. 6. (4) (a)]

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.