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
Jun 3, 2020	2020_833763_0009	004951-20	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

IANA MOLOGUINA (763)

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): May 14 and 22, 2020 (on-site); May 15, 19, and 20, 2020 (off-site).

The following intake was completed during this Critical Incident System (CIS) inspection:

Log #004951-20 (CIS # 2472-000001-20) was related to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Personal Support Workers (PSW) and residents.

During the course of this inspection, the inspector reviewed resident clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provision.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. (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 resident #001 as specified in the plan.

The MLTC received a CIS report on a specified date, detailing a fall incident involving resident #001 which resulted in transfer to hospital and significant change in health status.

A review of resident #001's health record indicated they were at risk for falls and had a history of climbing out of bed when they were restless. Interventions in the plan of care to manage resident #001's falls risk included ensuring a call bell was within reach of the resident, and to remind the resident to use the call bell for assistance given their physical and cognitive limitations.

Inspector observed resident #001 in their room on a specified date, and noted the resident was lying in their bed. The call bell was observed to be tucked behind resident #001's bedside table, out of reach of the resident. When asked, resident #001 did not know where the call bell was.

Inspector asked RN #102 why the call bell was tucked behind the bedside table, and RN #102 said that they were unsure. RN #102 then found the call bell, and clipped it to resident #001's bed linen, confirming with the resident that the call bell was now accessible to them. When interviewed, RN #102 indicated that it was the home's expectation that call bells were accessible to residents at all times, and that, if resident #001's care plan interventions included a specific intervention to manage their falls risk, such as ensuring the call bell was within reach, staff were to provide this intervention to resident #001 as indicated in the plan.

During interview, Administrator #100 indicated that it was the home's expectation of staff to ensure that the care interventions as set out in the resident's plan of care were provided to the resident as specified in the plan. [s. 6. (7)]

2. As a result of non-compliance found while inspecting resident #001's fall, the sample size was expanded to include resident #002.

A review of resident #002's health record indicated they were at risk for falls, and had several interventions included in their plan of care to manage their falls risk, including a clip alarm to be used when resident #002 used their assistive device.

Inspector observed resident #002 in their room on an indicated date, and noted the resident was sleeping in their assistive device beside their bed. A clip alarm was not

visible on observation.

RN #101 checked on the resident and confirmed the clip alarm was not available. RN #101 asked PSW #103, who was the regular PSW for resident #002, where the clip alarm was. PSW #103 could not find it.

During interview, PSW #103 confirmed that they were the PSW who provided care for resident #002 on the specified date and that they were the one who encouraged resident #002 to sit in their assistive device at the time of observation. PSW #103 confirmed they assisted resident #002 in their assistive device prior to leaving resident #002’s room to attend to other duties, however did not attach the clip alarm to the resident as they could not find it. PSW #103 confirmed they knew the resident required a clip alarm and did not ensure that this intervention was provided to the resident as indicated in the plan. [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.

Issued on this 15th day of June, 2020

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

Original report signed by the inspector.