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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 23, 2017	2017_263524_0003	033725-16	Resident Quality Inspection

Licensee/Titulaire de permis

CRAIGWIEL GARDENS
221 MAIN STREET R. R. #1 AILSA CRAIG ON N0M 1A0

Long-Term Care Home/Foyer de soins de longue durée

CRAIGHOLME
221 MAIN STREET R. R. #1 AILSA CRAIG ON N0M 1A0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

INA REYNOLDS (524), ADAM CANN (634), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 11, 12, 13, 16, 17, 2017.

The following intake was completed within the RQI:
Log # 031494-16 IL-47725-LO Complaint related to allegations of Abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Director of Food Service, the Director of Life Enrichment, one Registered Nurse, five Registered Practical Nurses, one Registered Dietitian, three Personal Support Workers, two Dietary Aides, the Residents' Council Representative, a Family Council Representative, 21 residents and three family members.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, medication administration, a medication storage area, resident/staff interactions, infection prevention and control practices, reviewed clinical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, internal investigation notes, relevant policies and procedures of the home, and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

2 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	Legendé 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).

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 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.

A resident was observed in their bed on a specific date, with bed rails in the engaged position. During interview with the resident, they stated that they used the bed rails for bed mobility and transfer. The resident stated that without the bed rails, they would have to call staff to assist. The bed rail logo at the head of the bed for this resident stated the use of bed rails.

A "Bed Rail Assessment" in Point Click Care, dated for a specific date, indicated that the resident used bed rails for mobility.

A Registered Nurse (RN) stated during stage one staff interviews, that the resident used a bed rail for bed mobility. On a specific date and time, the RN stated during interview that residents that used bed rails for bed mobility should be coded in Section G6b in the Minimum Data Set (MDS) assessment.

The resident was coded in the last Minimum Data Set (MDS) review assessment Section G6b as bed rails were not used for bed mobility or transfer.

On January 16, 2017, the Director of Care reviewed the clinical record for the resident and stated that the MDS coding should have included the use of bed rails for bed mobility, and that staff and others involved in the different aspects of care collaborated with each other in their assessments of the residents so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Observation of a resident's bed system during stage one of the RQI revealed bed rails in use and again one week later, while the resident was in bed and asleep.

Review of the resident's plan of care revealed the absence of documentation related to the use of bed rails. Review of the resident's bed rail logo at the head of the bed and the most recent MDS review assessment on a specific date, indicated that the resident did not use bed rails. Record review of the Bed Rail Assessment on an identified date, indicated the resident did not use either rail and was able to "safely enter and exit the bed".

Upon interview with a Registered Nurse on a specific date and time, it was stated that the resident did not require the use of bed rails and the care set out in the plan of care was not provided as planned.

Upon interview with the Director of Care on January 16, 2017, it was said that the care set out in the plan of care including the resident's bed logo for bed rails should have been followed.

The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified 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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and to ensure 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or might occur, immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone.

An anonymous complaint was submitted to the Ministry of Health and Long Term Care alleging the home was aware of an alleged incident of abuse to an identified resident by a staff member and did not submit a report to the Ministry of Health and Long Term Care as required.

Review of the progress notes for the resident recounted an event that indicated reasonable grounds to suspect that a resident had been abused.

A review of the Ministry's Critical Incident Reporting system failed to identify a Critical Incident System report in relation to this incident.

The Administrator stated during interview they were aware of the incident, the home had completed an internal investigation and actions were taken in response to the incident. Further to this, the Administrator stated that a Critical Incident System Report should have been submitted to the Ministry of Health and Long Term Care, but it was not. [s. 24. (1)]

Issued on this 10th day of February, 2017

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

Original report signed by the inspector.