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

London Service Area Office
130 Dufferin Avenue 4th floor
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Amended Public Copy/Copie modifiée 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
Jan 22, 2020	2019_797740_0021 (A1)	014245-19	Complaint

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

Amended by SAMANTHA PERRY (740) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On January 15, 2020, a request for an extension of the compliance due date of February 10, 2020, for Compliance #003 issued in inspection #2019_797740_0021 was received from Wayne Williams, Chief Executive Officer for Craigholme Nursing Home. The new compliance due date requested was April 30, 2020. After a teleconference on January 21, 2020 with home management staff, LSAO Inspection Managers and Inspectors an extension was agreed upon with a new compliance due date of April 15, 2020.

Issued on this 22nd day of January, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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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

Amended by SAMANTHA PERRY (740) - (A1)

Amended 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): September 09, 10, 11, 12, 13, 16, 17, 18, 19, 20, 24, 26, 27, 30, October 01, 02, 03 & 07, 2019.

The following Complaint intake was completed within this inspection:

Log #014245-19 related to care concerns.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, Director of Care, Assistant Director of Care, Director of Food Services, Director of Environmental Services, Human Resources Manager, Quality Manager, Maintenance Staff, Director of the Adult Day Program, Admission Coordinator of the Adult Day Program, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Reporting and Complaints
Training and Orientation

During the course of the original inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **3 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. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

The licensee has failed to ensure that staff who have provided direct care to residents have received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations

In accordance with O. Reg. 79/10, s. 219 (2), which states, ”Despite subsection (1), retraining in an area described in paragraph 2 or 10 of subsection 76 (2) of the Act is not required for a person if, since the last training or retraining, there has been no change in the area that is relevant to the person’s responsibilities”.

Section r. 221 (1) of O. Reg. 79/10 states “For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

The Ministry of Long-Term Care (MOLTC) received a complaint regarding several resident related care concerns.

The clinical record for an identified resident was reviewed and showed the resident was admitted for a respite stay and discharged on specific dates. During the identified resident's respite stay, the care plan was not reviewed or revised.

A Registered Nurse (RN) said that the admission and assessment process should be the same for all residents in the home. The RN stated that on admission medication reconciliation, updating of the care plan, skin assessments, bowel and bladder assessments and dietary assessments should be completed. The RN said that the registered staff were not completing assessments when identified residents were admitted and were not sure if this was based on policy or based on the process the home was following in the past. When asked how direct care staff would know what kind of care was required for residents, when inconsistencies related to the processes and responsibilities performed during a respite stay were identified, the RN stated they did not know.

The Assistant Director of Care (ADOC) said that the home had purchased and implemented new policies as of last year, 2018.

The home's policy, Respite/Short Stay/Convalescent Care, RC-03-01-04, last updated June 2019, stated the following under the heading, ''Policy'':
- The nurse will assess and provide the necessary care and services to all residents admitted for respite, short-stay or convalescent care in accordance with provincial standards for long term care.
Additionally, under the heading, ''Procedures'':
- The interdisciplinary team will:
1. Develop an initial plan of care for the respite/short stay/convalescent care

resident within 24 hours.
3. Complete additional required assessments for the respite/short stay/convalescent care resident based on resident need and as per jurisdictional regulatory requirements.

The Director of Care (DOC) said, when asked if all staff had been trained on the new policies, that as far as they knew and based on what they had been told, the home had all staff in the home review the new policies. When asked if the home had a written record of the staff who had attended the training, the DOC said that the Quality Manager (QM) would have the records.

A review of the home's records related to annual staff training showed the following:
- 20 per cent of staff members attended the first education session;
- 9 per cent of staff members attended the second education session;
- 36 per cent of staff members attended the third education session;
- 39 per cent of staff members attended the fourth education session, and;
- 41 per cent of staff members attended the fifth education session.

The FSM said that they were the lead for staff training related to health and safety only and that the Human Resource Manager (HRM) may have access or know where additional training records were kept in the home.

The HRM said that they did not have any additional records for annual staff training and were the lead for new staff orientation training only. The HRM said that they did not know who the training lead was for annual staff training.

The ADOC reviewed the "Policy and Procedures Roll Out Plan" document and stated that the education related to the new policies and procedures were mandatory for all staff. When asked if the new policies and procedures were considered to be a new process for staff and if they would expect that all direct care staff were trained on the new policies, the ADOC said yes.

The ADOC confirmed that signatures were missing on the staff attendance sheets and said that emails were sent out to the staff members not in attendance with all information covering the new policies. When asked how the home ensured that the staff reviewed and understood the information emailed to them, the DOC said that they did not know.

The licensee has failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in any other areas and at times or at intervals provided for in the regulations.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Findings/Faits saillants :

The licensee has failed to ensure that a 24-hour admission care plan was developed within 24-hours of the resident's admission to the home.

The Ministry of Long-Term Care (MOLTC) received a complaint regarding several care concerns related to an identified resident.

Review of the identified resident's Census showed:
A specific date on which the identified resident was admitted to the home and the specific date on which the identified resident was discharged from the home.

A Registered Practical Nurse (RPN) said that they would complete any resident focused assessments requested by the Registered Nurse (RN) to help the RN complete the admission process. When asked if there was a different admission process for a long-term resident, first-time respite/short-stay resident or repeat respite/short-stay resident related to the assessments being completed, the RPN said no and that they would complete the same assessments for each resident every time they were admitted to the long-term care home.

Review of an identified resident's clinical records showed that the resident's care plan related to various care areas was not updated or revised and there were no documented assessments for the resident's respite admission.

The Assistant Director of Care (ADOC) said, that the 24-hour admission care plan, including assessments and admission checklists should have been completed.

The home's policy, Respite/Short Stay/Convalescent Care, RC-03-01-04, last updated June 2019, stated the following under the heading, ''Policy'':
- The nurse will assess and provide the necessary care and services to all residents admitted for respite, short-stay or convalescent care in accordance with provincial standards for long term care.
Additionally, under the heading, ''Procedures'', The interdisciplinary team will:
- Develop an initial plan of care for the respite/short stay/convalescent care resident within 24 hours.
- Complete additional required assessments for the respite/short stay/convalescent care resident based on resident need and as per jurisdictional regulatory requirements.

The Director of Care (DOC) said, that they didn't know why there were no assessments completed for the identified resident's 24-hour care plan and it was the home's expectation that the assessments be completed.

The ADOC provided a record of all respite/short stay residents' admissions to the home.

Review of an identified resident's Census showed:
A specific date on which the identified resident was admitted to the home and the specific date on which the identified resident was discharged from the home.

Review of the identified resident's clinical records showed that, the resident's care plan related to various care areas was not updated or revised and only one assessment for the identified resident was documented.

The licensee has failed to ensure that the identified residents' 24-hour admission care plans were developed and were based on assessments to determine the residents' needs and preferences.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

The licensee has failed to ensure that every written or verbal complaint made to the licensee or staff member concerning the care of a resident had a documented record kept in the home.

The Ministry of Long-Term Care (MOLTC) received a complaint regarding several resident related care concerns.

The complainant informed inspectors that they had a meeting with the home related to their concerns; however, the home did not contact the complainant after the meeting, to follow up and ensure the complainant's concerns were effectively

addressed.

The Assistant Director of Care (ADOC) stated that notes were not taken for the meeting held with the complainant and they did not fill out a Craigwiel Gardens ‘’Complaint Investigation Form’’ but had investigation notes.

A review of the investigation notes showed there was communication between a Registered Nurse, the Chief Executive Officer (CEO), the ADOC and the Human Resources Manager (HRM). The communication note said the complainant wanted a meeting with the home to discuss their care concerns and it was acknowledged by the RN that the home would address the concerns.

There were no documented records of the meeting held with the complainant kept in the home.

The home’s “Complaints and Customer Service’’ policy, RC-09-01-04, last updated June 2019, was reviewed and showed:
‘’The home will comply with relevant regulatory requirements or provincial, regional, local health and other authorities’ written directives regarding concerns/complaints. The management and resolution of issues will ensure that residents, families and Substitute Decision Makers (SDMs) and other stakeholders receive a response within required legislative timeframes and the addressed concerns are documented.
The Administrator/Designate and/or the Department Manager/Designate shall ensure that:
5. Take notes of all interview questions, observations and other actions related to the investigation.
7. Each contact with the complainant should be recorded on the Contact Log by the person making the contact.
8. Keep all the materials related to the investigation together in one file for future retrieval and quality improvement auditing purposes.
10. Provide written response at conclusion of investigation. Review draft with Regional Director (RD), and Communications where appropriate, prior to release. The written response will include:
a. What the home has done to resolve the complaint. This will be shared with the complainant/resident/SDM/family/staff or any other individuals involved.
b. Depending on the severity of the complaint, a disclosure meeting may be required, and the written response can be provided to the complainant at the meeting".

During an interview, the CEO stated that the home did not have a complete record, kept in the home, for the home's investigation, telephone calls, meetings, actions and resolutions related to the complainant's care concerns.

A review of the home's complaint binder showed a Craigwiel Gardens "Complaint Investigation Form" which documented concerns received on an identified date for a resident. The form documented that the resident was not happy with the actions taken, the home did not document the final resolution, every date in which a response was provided, a description of the response, or any response made by the complainant.

The Director of Care (DOC) said, that the type of action taken to resolve the complaint, including the date of the action, the final resolution, every date on which any response was provided to the complainant, a description of the response and any response made in turn by the complainant was not documented on the Craigwiel Gardens ''Complaint Investigation Form'' and should have been.

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operation of the home was dealt with in accordance with r. 101(2) of the O/Reg. 79/10.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

Ontario

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Ministère des Soins de longue durée

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Issued on this 22nd day of January, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SAMANTHA PERRY (740) - (A1)
Inspection No. / No de l'inspection :	2019_797740_0021 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	014245-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 22, 2020(A1)
Licensee / Titulaire de permis :	Craigwiel Gardens 221 Main Street, R. R. #1, AILSA CRAIG, ON, N0M-1A0
LTC Home / Foyer de SLD :	Craigholme 221 Main Street, R.R. #1, AILSA CRAIG, ON, N0M-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Wayne Williams

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Craigwiel Gardens, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

Specifically, the licensee must ensure the following:

a) All management of the home will receive training on the policies and procedures for all required programs. A written record will be kept of all training including staff names, dates and training content, to ensure that all management received the training.

b) All direct care staff (registered and non-registered) working in the home will receive education and training on the policies and procedures for all required programs, pursuant to s. 48 of the LTCHA. A written record is kept of all training including staff names, dates and training content, to ensure that all staff received the training.

c) The Chief Executive Officer/Director of Care/Assistant Director of Care will develop and implement an audit to assess the staff's level of knowledge and application of the training materials, including processes and procedures as outlined in s. 76 of the LTCHA, to identify further training needs and will provide re-training as applicable. The audit must include who is responsible, audit dates, timelines, corrective actions taken and outcomes of the analysis. A written record must be kept in the home of all the audit materials.

Grounds / Motifs :

1. The licensee has failed to ensure that staff who have provided direct care to residents have received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations

In accordance with O. Reg. 79/10, s. 219 (2), which states, "Despite subsection (1), retraining in an area described in paragraph 2 or 10 of subsection 76 (2) of the Act is not required for a person if, since the last training or retraining, there has been no

change in the area that is relevant to the person's responsibilities".

Section r. 221 (1) of O. Reg. 79/10 states "For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

The Ministry of Long-Term Care (MOLTC) received a complaint regarding several resident related care concerns.

The clinical record for an identified resident was reviewed and showed the resident was admitted for a respite stay and discharged on specific dates. During the identified resident's respite stay, the care plan was not reviewed or revised.

A Registered Nurse (RN) said that the admission and assessment process should be the same for all residents in the home. The RN stated that on admission medication reconciliation, updating of the care plan, skin assessments, bowel and bladder assessments and dietary assessments should be completed. The RN said that the registered staff were not completing assessments when identified residents were admitted and were not sure if this was based on policy or based on the process the home was following in the past. When asked how direct care staff would know what kind of care was required for residents, when inconsistencies related to the processes and responsibilities performed during a respite stay were identified, the RN stated they did not know.

The Assistant Director of Care (ADOC) said that the home had purchased and implemented new policies as of last year, 2018.

The home's policy, Respite/Short Stay/Convalescent Care, RC-03-01-04, last updated June 2019, stated the following under the heading, ''Policy'':
- The nurse will assess and provide the necessary care and services to all residents admitted for respite, short-stay or convalescent care in accordance with provincial standards for long term care.
Additionally, under the heading, ''Procedures'':
- The interdisciplinary team will:
1. Develop an initial plan of care for the respite/short stay/convalescent care resident within 24 hours.
3. Complete additional required assessments for the respite/short stay/convalescent care resident based on resident need and as per jurisdictional regulatory requirements.

The Director of Care (DOC) said, when asked if all staff had been trained on the new policies, that as far as they knew and based on what they had been told, the home had all staff in the home review the new policies. When asked if the home had a written record of the staff who had attended the training, the DOC said that the Quality Manager (QM) would have the records.

A review of the home's records related to annual staff training showed the following:
- 20 per cent of staff members attended the first education session;
- 9 per cent of staff members attended the second education session;
- 36 per cent of staff members attended the third education session;
- 39 per cent of staff members attended the fourth education session, and;
- 41 per cent of staff members attended the fifth education session.

The FSM said that they were the lead for staff training related to health and safety only and that the Human Resource Manager (HRM) may have access or know where additional training records were kept in the home.

The HRM said that they did not have any additional records for annual staff training and were the lead for new staff orientation training only. The HRM said that they did not know who the training lead was for annual staff training.

The ADOC reviewed the "Policy and Procedures Roll Out Plan" document and stated that the education related to the new policies and procedures were mandatory for all staff. When asked if the new policies and procedures were considered to be a new

process for staff and if they would expect that all direct care staff were trained on the new policies, the ADOC said yes.

The ADOC confirmed that signatures were missing on the staff attendance sheets and said that emails were sent out to the staff members not in attendance with all information covering the new policies. When asked how the home ensured that the staff reviewed and understood the information emailed to them, the DOC said that they did not know.

The licensee has failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in any other areas and at times or at intervals provided for in the regulations.

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was widespread, and the home had no previous history of non-compliance in this area. (740)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2020

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. 24-hour admission care plan

Order / Ordre :

Specifically the licensee must:

a) Ensure that a 24-hour admission care plan is developed for identified residents and all other residents, including respite/short stay/convalescent care residents, and is communicated to staff within 24 hours of the residents' admission to the home to achieve compliance with s. 24 (1) and (2) of the O/Reg. 79/10.

b) Ensure that the care plan for the identified residents and any other residents, including respite/short stay/convalescent care residents, is based on an assessment of the resident and the needs and preferences of the resident related to, at a minimum, section r. 24(2) of O. Reg. 79/10. A documented record will be kept of all completed assessments.

c) Ensure that all management and registered staff working in the home receive training on the home's policy "Respite/Short Stay/Convalescent Care" RC-03-01-04. A written record will be kept of all training including staff names, dates and training content, to ensure that all staff received the training.

d) Create a quality improvement plan to ensure that an initial plan of care, including required assessments are completed within the 24 hours admission time frame for any respite, short stay or convalescent care resident. The plan must include the admission procedure, responsible persons, timelines and tools to be used.

Grounds / Motifs :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to ensure that a 24-hour admission care plan was developed within 24-hours of the resident's admission to the home.

The Ministry of Long-Term Care (MOLTC) received a complaint regarding several care concerns related to an identified resident.

Review of the identified resident's Census showed:
A specific date on which the identified resident was admitted to the home and the specific date on which the identified resident was discharged from the home.

A Registered Practical Nurse (RPN) said that they would complete any resident focused assessments requested by the Registered Nurse (RN) to help the RN complete the admission process. When asked if there was a different admission process for a long-term resident, first-time respite/short-stay resident or repeat respite/short-stay resident related to the assessments being completed, the RPN said no and that they would complete the same assessments for each resident every time they were admitted to the long-term care home.

Review of an identified resident's clinical records showed that the resident's care plan related to various care areas was not updated or revised and there were no documented assessments for the resident's respite admission.

The Assistant Director of Care (ADOC) said, that the 24-hour admission care plan, including assessments and admission checklists should have been completed.

The home's policy, Respite/Short Stay/Convalescent Care, RC-03-01-04, last updated June 2019, stated the following under the heading, ''Policy'':
- The nurse will assess and provide the necessary care and services to all residents admitted for respite, short-stay or convalescent care in accordance with provincial standards for long term care.
Additionally, under the heading, ''Procedures'', The interdisciplinary team will:
- Develop an initial plan of care for the respite/short stay/convalescent care resident within 24 hours.
- Complete additional required assessments for the respite/short stay/convalescent care resident based on resident need and as per jurisdictional regulatory requirements.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

The Director of Care (DOC) said, that they didn't know why there were no assessments completed for the identified resident's 24-hour care plan and it was the home's expectation that the assessments be completed.

The ADOC provided a record of all respite/short stay residents' admissions to the home.

Review of an identified resident's Census showed:
A specific date on which the identified resident was admitted to the home and the specific date on which the identified resident was discharged from the home.

Review of the identified resident's clinical records showed that, the resident's care plan related to various care areas was not updated or revised and only one assessment for the identified resident was documented.

The licensee has failed to ensure that the identified residents' 24-hour admission care plans were developed and were based on assessments to determine the residents' needs and preferences.

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was patterned, and the home had no previous history of non-compliance in this area. (740)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 10, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Order / Ordre :

Specifically the licensee must:

a) All management must receive training related to the process of documenting complaints, including but not limited to a review of the home's policy "Complaints and Customer Service" RC-09-01-04 and the home must keep a written record of the training received.

b) Create a quality improvement plan to ensure that every written or verbal complaint made to the licensee or staff member, is documented and a written record is kept in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or staff member concerning the care of a resident had a documented record kept in the home.

The Ministry of Long-Term Care (MOLTC) received a complaint regarding several resident related care concerns.

The complainant informed inspectors that they had a meeting with the home related to their concerns; however, the home did not contact the complainant after the meeting, to follow up and ensure the complainant's concerns were effectively addressed.

The Assistant Director of Care (ADOC) stated that notes were not taken for the meeting held with the complainant and they did not fill out a Craigwiel Gardens ''Complaint Investigation Form'' but had investigation notes.

A review of the investigation notes showed there was communication between a Registered Nurse, the Chief Executive Officer (CEO), the ADOC and the Human Resources Manager (HRM). The communication note said the complainant wanted a meeting with the home to discuss their care concerns and it was acknowledged by the RN that the home would address the concerns.

There were no documented records of the meeting held with the complainant kept in the home.

The home's "Complaints and Customer Service'' policy, RC-09-01-04, last updated June 2019, was reviewed and showed:
''The home will comply with relevant regulatory requirements or provincial, regional, local health and other authorities' written directives regarding concerns/complaints. The management and resolution of issues will ensure that residents, families and Substitute Decision Makers (SDMs) and other stakeholders receive a response within required legislative timeframes and the addressed concerns are documented. The Administrator/Designate and/or the Department Manager/Designate shall ensure that:
5. Take notes of all interview questions, observations and other actions related to the investigation.
7. Each contact with the complainant should be recorded on the Contact Log by the person making the contact.
8. Keep all the materials related to the investigation together in one file for future retrieval and quality improvement auditing purposes.
10. Provide written response at conclusion of investigation. Review draft with Regional Director (RD), and Communications where appropriate, prior to release. The written response will include:

a. What the home has done to resolve the complaint. This will be shared with the complainant/resident/SDM/family/staff or any other individuals involved.
b. Depending on the severity of the complaint, a disclosure meeting may be required, and the written response can be provided to the complainant at the meeting".

During an interview, the CEO stated that the home did not have a complete record, kept in the home, for the home's investigation, telephone calls, meetings, actions and resolutions related to the complainant's care concerns.

A review of the home's complaint binder showed a Craigwiel Gardens "Complaint Investigation Form" which documented concerns received on an identified date for a resident. The form documented that the resident was not happy with the actions taken, the home did not document the final resolution, every date in which a response was provided, a description of the response, or any response made by the complainant.

The Director of Care (DOC) said, that the type of action taken to resolve the complaint, including the date of the action, the final resolution, every date on which any response was provided to the complainant, a description of the response and any response made in turn by the complainant was not documented on the Craigwiel Gardens ''Complaint Investigation Form'' and should have been.

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operation of the home was dealt with in accordance with r. 101(2) of the O/Reg. 79/10.

During this inspection, this non-compliance was found to have a severity of minimal risk to the residents. The scope was patterned, and the home had no previous history of non-compliance in this area. (740)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2020(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of January, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by SAMANTHA PERRY (740) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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Service Area Office / Bureau régional de services : London Service Area Office