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
Mar 2, 2021	2021_648741_0003	024843-20, 025883-20	Critical Incident System

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

AYESHA SARATHY (741)

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): February 17, 18, 22, 23 and 24, 2021

The following Critical Incident Systems (CISs) were inspected as a part of this inspection:

CIS #2622-000083-20 related to falls prevention and management
CIS #2622-000086-20 related to an allegation of staff to resident neglect

During the course of the inspection, the inspector(s) spoke with the Receptionist, a Health Screener, a Housekeeper, Personal Support Workers (PSWs), Registered Nurses (RNs), the Acting Director of Care (Acting DOC), the Chief Executive Officer (CEO) and two residents.

During the course of this inspection, the Inspector also completed an Infection Prevention and Control (IPAC) Assessment, reviewed resident clinical records, the home's investigative notes, relevant policies and procedures and observed residents and IPAC practices in the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

The licensee has failed to ensure that a resident's Personal Assistance Services Device (PASD), which had the effect of limiting or inhibiting their movement and from which they were not able to, physically or cognitively, release themselves, was used to assist them with a routine activity of living only when it was included in their plan of care.

A resident was observed on multiple occasions during the inspection using a PASD.

The home's procedure to implement a PASD for a resident included: an assessment for the use of the PASD; approval for the PASD by a physician, registered staff, Occupational Therapist or Physiotherapist; and consent from the resident and/or the Substitute Decision Maker (SDM). The policy also stated that the resident's plan of care must include all of the above components.

The resident's plan of care did not include an assessment, approval or resident and/or SDM consent for their PASD.

The Acting Director of Care (DOC) said that staff missed doing a PASD assessment, getting a doctor's order, notifying the resident's SDM and including the PASD in their plan of care when it was implemented.

Sources: the resident's plan of care, including progress notes, care plan, assessments, and paper chart; the home's "Personal Assistance Service Devices" policy, #RC-22-01-05, last revised December 2019; observations of the resident; interviews with the Acting DOC and other staff.

Issued on this 3rd day of March, 2021

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

Original report signed by the inspector.