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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Public Copy/Copie 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
Sep 16, 2021	2021_778563_0018	009283-21, 013012-21	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

MELANIE NORTHEY (563)

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): August 31, September 1, 2 and 7, 2021

The following Critical Incident (CI) intakes were completed within this inspection:
Log #009283-21 / CI #2622-000019-21 related to fall prevention
Log #013012-21 / CI #2622-000021-21 related to fall prevention

During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, the Ward Clerk, the Environmental Service Manager, Housekeepers, and residents.

The inspector conducted a tour of the home and made observations of residents and care, meal and snack service, and resident/staff interactions. The inspector also observed the documentation system for air temperature monitoring, as well as the infection prevention and control practices and active visitor screening. Relevant resident clinical records, policies and procedures were also reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to the use of a specific falls prevention strategy.

The falls prevention strategy was observed in use. The care kardex posted at the head of the bed documented that the falls prevention strategy was not used for the resident since it was not circled as an intervention for fall prevention. The care plan in Point Click Care (PCC) documented staff were to ensure the falls prevention strategy was in place.

The Registered Nurse (RN) stated the posted care kardex identified that the resident did not use a specific falls prevention strategy. The RN verified the resident did use a specific falls prevention strategy and there was no clear direction for staff providing the specific falls prevention strategy for the resident.

Sources: clinical record for the resident, observations and staff interviews. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care related to fall

prevention strategies for a resident was provided to the resident as specified in the plan.

A Critical Incident System Report documented that a resident sustained a fall and injury. There was also an anonymous complaint submitted with reported concerns related to the fall of the resident.

The care plan stated the resident identified specific falls prevention strategies and staff assistance for care.

A Personal Support Worker (PSW) stated they did not provide the specific care and staff assistance planned for the resident and the resident sustained a fall and injury. The Director of Care (DOC) stated the resident required constant monitoring, and the PSW should not have stepped out or had taken their eyes off the resident. The DOC stated the resident should have been actively supervised during the entire care routine. The total assistance for the entire care routine was not provided as planned and the resident fell and sustained an injury.

B) During the course of the inspection, the resident was also observed with their falls prevention strategy not in use.

The care plan in PCC stated the resident was to have the falls prevention strategy in use. The RN verified the falls prevention strategy was not in place and should have been when the resident was up in their wheelchair.

Sources: Critical Incident Report, Complaint Report, clinical record for the resident, observations and staff interviews. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to the proper positioning of the resident when in their wheelchair.

The resident was observed seated in a wheelchair that was inclined and wearing a seat belt that was very loose around their waist and the resident was able to slip both hands under the belt with room to spare.

The care plan in PCC had a focus related to the use of a Personal Assistance Services Device (PASD) with the goal to maintain current and appropriate use of the PASD and to maintain proper positioning when in the wheelchair.

The Registered Practical Nurse shared that the resident required a seat belt and stated the seat belt was used to position the resident in their wheelchair safely. A PSW verified the resident was at risk of falling if the resident sat closer to the edge of the wheelchair seat and was not properly fitted for their seat belt.

The DOC verified the intent of the seat belt as a PASD for the resident was to ensure safe positioning in the wheelchair, and if the belt was too loose the resident could easily sit forward beyond the edge of the seat jeopardizing their proper positioning and safety when in the wheelchair. The DOC stated the expectation for fitting a seat belt that has been assessed as a PASD for positioning was two fingers sideways as a measurement.

Sources: clinical record for the resident, observations and staff interviews.[s. 6. (7)]

4. The licensee failed to ensure that the care set out in the plan of care related to the use of falls prevention strategies for a resident was provided to the resident as specified in the plan.

The Critical Incident System Report documented that the resident had a witnessed fall and injury. The falls prevention strategies were not in place for the resident at the time of the fall. A PSW and RN were in the room assisting the resident's roommate with care when the resident had a fall from the bed sustaining a significant injury.

The care plan in PCC documented the use of specific falls prevention strategies and an assessment completed six days prior to the fall documented that the resident had risk factors that would contribute to their falls risk.

The resident had a significant negative health outcome post fall and passed away several days later.

The RN and PSW verified the falls prevention strategies planned for the resident were not in place at the time of the fall.

The resident fell from a height that was not appropriate or safe onto a hard surface. The interventions in place to keep the resident safe were not in use and the resident had a significant injury and negative health outcome that the resident did not fully recover from and subsequently passed away several days later.

Sources: Critical Incident Report, clinical record for the resident, and staff interviews. [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed, and the plan of care reviewed and revised when the resident's fall prevention strategies changed and they were no longer necessary.

The current care plan in PCC documented a falls prevention program for the resident that included specific falls prevention strategies that were implemented late 2020 and early 2021.

The resident was observed without the planned strategies in place on more than one occasion. The PSW verified that the resident did not have the specific falls prevention strategies in place.

The RN verified the specific strategies were documented as interventions in place for fall prevention in PCC and were no longer in use for the resident. The DOC stated there were several interventions tried and reviewed with the resident's family for risk and benefit. The DOC verified there was no assessment completed when the resident's fall strategies changed, and the resident was not reassessed when interventions were discontinued, and the care plan was not revised when those fall prevention strategies changed and were no longer necessary.

Sources: clinical record for the resident, observations and staff interviews.[s. 6. (10) (b)]

Additional Required Actions:

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

Issued on this 16th day of September, 2021

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	MELANIE NORTHEY (563)
Inspection No. / No de l’inspection :	2021_778563_0018
Log No. / No de registre :	009283-21, 013012-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 16, 2021
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 :	Ernie Harris

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. 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.
Specifically, the licensee must:
a) Ensure the plan of care for a resident is reviewed and revised to include all fall prevention strategies when the resident is in bed, wheelchair and during their toileting routine. The plan of care must provide clear directions to staff and others who provide direct care to the resident. Ensure a Personal Support Worker (PSW) receives education related to resident monitoring during toileting, and safe transferring and positioning techniques. The home must keep a written record of the education that was provided, who provided the education and a signature of attendance.
b) Ensure the plan of care for a resident is reviewed and revised to include all safety measures in place to ensure the resident is safely positioned in their wheelchair at all times. The home is to complete safety checks for the resident at times determined by the home to confirm the seat belt is correctly applied and fitted to the resident. The home must keep a written record of the safety checks and who was responsible.
c) Ensure the registered nursing staff and PSWs are provided education to ensure residents remain safe and properly positioned in bed with all interventions in place while unattended. The home must keep a written record of the education provided, who provided the education and signatures of attendance.

Grounds / Motifs :

1. A) The licensee failed to ensure that the care set out in the plan of care related to fall prevention strategies for a resident was provided to the resident as specified in the plan.

A Critical Incident System Report documented that a resident sustained a fall and injury. There was also an anonymous complaint submitted with reported concerns related to the fall of the resident.

The care plan stated the resident identified specific falls prevention strategies and staff assistance for care.

A Personal Support Worker (PSW) stated they did not provide the specific care and staff assistance planned for the resident and the resident sustained a fall and injury. The Director of Care (DOC) stated the resident required constant monitoring, and the PSW should not have stepped out or had taken their eyes off the resident. The DOC stated the resident should have been actively supervised during the entire care routine. The total assistance for the entire care routine was not provided as planned and the resident fell and sustained an injury.

B) During the course of the inspection, the resident was also observed with their falls prevention strategy not in use.

The care plan in PCC stated the resident was to have the falls prevention strategy in use. The RN verified the falls prevention strategy was not in place and should have been when the resident was up in their wheelchair.

Sources: Critical Incident Report, Complaint Report, clinical record for the resident, observations and staff interviews. (563)

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to the proper positioning of the resident when in their wheelchair.

The resident was observed seated in a wheelchair that was inclined and wearing a seat belt that was very loose around their waist and the resident was able to slip both hands under the belt with room to spare.

The care plan in PCC had a focus related to the use of a Personal Assistance Services Device (PASD) with the goal to maintain current and appropriate use of the PASD and to maintain proper positioning when in the wheelchair.

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The DOC verified the intent of the seat belt as a PASD for the resident was to ensure safe positioning in the wheelchair, and if the belt was too loose the resident could easily sit forward beyond the edge of the seat jeopardizing their proper positioning and safety when in the wheelchair. The DOC stated the expectation for fitting a seat belt that has been assessed as a PASD for positioning was two fingers sideways as a measurement.

Sources: clinical record for the resident, observations and staff interviews. (563)

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The care plan in PCC documented the use of specific falls prevention strategies and an assessment completed six days prior to the fall documented that the resident had risk factors that would contribute to their falls risk.

The resident had a significant negative health outcome post fall and passed away several days later.

The RN and PSW verified the falls prevention strategies planned for the resident were not in place at the time of the fall.

The resident fell from a height that was not appropriate or safe onto a hard surface. The interventions in place to keep the resident safe were not in use and

the resident had a significant injury and negative health outcome that the resident did not fully recover from and subsequently passed away several days later.

Sources: Critical Incident Report, clinical record for the resident, and staff interviews.

An order was made by taking the following factors into account:
Severity: There was actual harm to two residents related to falls prevention. There was potential for harm related to one resident's wheelchair safety.
Scope: The scope of this non-compliance for s. 6 (7) of the LTCHA involved one of three residents related to clear direction, one of three residents related to updating the plan of care when there was a change, and three of three residents related to providing the care as planned. The final scope was a pattern.
Compliance History: There was no history of non-compliance issued to the home related to s. 6 (7) of the legislation in the past 36 months. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 05, 2021

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 16th day of September, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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