Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
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Original Public Report

Report Issue Date: June 26, 2023
Inspection Number: 2023-1131-0002
Inspection Type: Critical Incident System
Licensee: Craigwiel Gardens
Long Term Care Home and City: Craigholme, Ailsa Craig

Lead Inspector	**Inspector Digital Signature**
Christina Legouffe (730)	Christina Legouffe Digitally signed by Christina Legouffe Date: 2023.06.26 12:14:34 -04'00'

Additional Inspector(s)
Cheryl McFadden (745)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 21, 22, 2023
The inspection occurred offsite on the following date(s): June 23, 2023

The following intake(s) were inspected:

- Intake: #00090292 - 2622-000010-23: related to a fall.
- Intake: #00015680 - 2622-000020-22: related to an incident which resulted in an injury to a resident.

The following intake (s) were completed during this inspection:

- Intake: #00003804- 2622-000010-22 related to a fall.
- Intake: #00013629-2622-000018-22- related to a fall.
- Intake: #00015979- 2622-000021-22- related to a fall.
- Intake: #00018954- 2622-000003-23 related to a fall.
- Intake: #00022115- 2622-000005-23: related to a fall.
- Intake: #00022275- 2622-000006-23: related to a fall.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary
A resident had a fall, which was reported to the Ministry of Long-Term Care by the home.

An intervention was added to the resident's plan of care, related to falls prevention, however, the intervention was not in place during an observation by an Inspector.

A Registered Nurse (RN) said that the resident did not have the specified intervention, currently and a Personal Support Worker, (PSW) said that the resident never had the specified intervention.

Assistant Director of Care (ADOC) confirmed that the intervention was added to the resident's plan of care, but was never put in place. The intervention was removed from the care plan by the ADOC after the inspector's observation and discussion with staff. There was no documented assessment before the intervention was removed from their plan of care.

An assessment stated that the care plan related to falls had been reviewed and was up to date for the resident. The ADOC said that the assessment was not consistent with what was actually in place for the resident, as the assessment stated that the care plan was up to date, but it was not.

Sources: Critical Incident Report, resident record review, interviews with a PSW, RN, and ADOC. [745]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a report related to an incident where a resident fell while being transferred by staff, which resulted in an injury.

A Registered Nurse and the Assistant Director of Care (ADOC) confirmed the resident had fallen while being transferred by a staff member. The staff member was re-educated related to safe transfers.

Sources: Critical Incident Systems Report, resident record review, interviews with an RN and the ADOC.

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WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee failed to comply with the home's falls prevention and management policy related to head injuries, included in the required falls prevention and management program in the home, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with. Specifically, staff did not comply with the licensee's "Neurological Signs/Head Injury Routine" Policy.

Summary and Rationale
Review of the home's Head Injury Routine (HIR) Policy stated that following an unwitnessed fall, the Registered Nursing staff would complete a head injury routine at specified time intervals.

The home submitted a report related to a resident, who had an unwitnessed fall.

The Assistant Director of Care (ADOC) said the resident's HIR was not completed as per the policy of the home.

The home's failure to follow their Head Injury Routine policy placed the resident at risk as staff had the potential to miss post fall injuries if regular assessments were not completed as required.

Sources: Review of resident clinical records, the home's "Neurological Signs/Head Injury Routine" policy, and interviews with the ADOC and other staff. [730]

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident, who had an area of altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Summary and Rationale
The home submitted a report related to a resident, who had an unwitnessed fall and sustained an injury.

A skin and wound assessment was initiated for the resident, however, the assessment was not completed.

The home's **"**Skin and Wound Care Management" policy stated that the registered staff would complete required electronic documentation for any new skin issue document with iPad Point Click Care (PCC) skin and wound, including photo assessment if resident consented.

The Assistant Director of Care (ADOC) said that the skin assessment for the resident's injury skin was not completed as per the expectations of the home.

There was minimal risk to the resident as a result of the skin assessment not being completed.

Sources: Review of resident clinical records, the home's "Skin and Wound Care Management" policy, and interviews with the ADOC and other staff. [730]