Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 3, 22, 28, 31, Nov 2, 2011	2011_088135_0016	Critical Incident

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

BONNIE MACDONALD (135)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Care, Environmental Services Manager, 1 Registered Nurse and 2 Health Care Aides.

During the course of the inspection, the inspector(s) reviewed resident's health records, training manuals, maintenance records and staff communication records.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. In record review observed, resident was not reassessed after returning to the home.

October 3, 2011 15:45-in interview, home's Administrator confirmed her expectation resident should have been reassessed, after returning to the home after sustaining injury in the home.
[LTCHA, 2007 S.O. c.8 s.6.(10)(b)]

2. In record review, observed resident sustained an injury, after being transferred with lift.

In interview Health Care Aide stated " We would know we would use the lift with resident as it would be on the chart or on the computer".

In record review, resident's plan of care, states resident is unsteady on their feet and requires limited assistance and is a two person transfer.

October 3, 2011 15:30-in interview, Director of Resident Care confirmed resident's plan of care did not provide clear direction for staff when the plan of care did not indicate resident was to be transferred using a lift.
[LTCHA, 2007 S.O. c.8 s.6.(1)(c)]

Issued on this 2nd day of November, 2011

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

Bonnie MacDonald