Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 24, 2013	2013_182128_0002	L-000011-13	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

RUTH HILDEBRAND (128)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 21, 2013

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, 1 Registered Nurse, 3 Personal Support Workers/Nurses Aides, 1 Dietary Aide and 2 Residents.

During the course of the inspection, the inspector(s) observed identified residents and their bedrooms, reviewed identified clinical records and reviewed posted information, as well as policies and procedures pertinent to the inspection.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. A review of a Critical Incident submitted to the MOHLTC revealed that the licensee failed to ensure that long-term actions, taken to correct the situation and prevent recurrence, were reported to the Director. The licensee identified immediate actions taken to prevent recurrence but noted that the long-term actions were the same. The licensee has implemented long-term actions to prevent recurrence, since that time, but they were not reported to the Ministry.

The Centralized Intake, Assessment and Triage Team (CIATT) requested an amendment be provided to the MOHLTC but an amendment was not sent.
The Director of Care acknowledged that the amendment request was not sent because the email from the CIATT was not opened and therefore, the home was not aware of the request.
The Executive Director indicated that long-term actions should be identified on all Critical Incident submissions. [s. 104. (1) 4.]

Issued on this 24th day of January, 2013

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

Ruth Hildebrand