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
Nov 8, 2013	2013_229213_0050	L-000808-13	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

RHONDA KUKOLY (213)

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): October 30, 2013

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Assistant Director of Resident Care, 2 Residents, 2 Registered Nurses and the Acting Director of Resident Care

During the course of the inspection, the inspector(s) made observations, reviewed health records and other relevant documentation

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Medication

Pain

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the written report include actions taken in response to the incident, including:
i. what care was given or action taken as a result of the incident, and by whom, and
ii. whether a physician or registered nurse in the extended class was contacted, as evidenced by:
1. The report indicated the physician was not contacted for 2 residents following the discovery of medication incidents.
2. The report did not include findings of the investigation or the actions taken to prevent recurrence or by whom.
3. The Assistant Director of Resident Care, the Acting Director of Care and the Executive Director confirmed that they were not aware of the investigation or findings relating to the above mentioned 2 medication incidents including what investigation was completed or the follow up and actions taken relating to the findings of the investigation. [s. 107. (4) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written reports include actions taken in response to an incident, to be implemented voluntarily.

WN #2: 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. (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary as evidenced by:
1. A Resident has a physician's order for pain medication. The plan of care did not include pain or interventions relating to pain relief.
2. The Assistant Director of Resident Care confirmed that it is an expectation that care plans include pain and pain relief interventions and did not. [s. 6. (10) (b)]

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Issued on this 8th day of November, 2013

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

Rhonda Kukoly