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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 2, 2015	2014_235507_0022	T-125-14	Resident Quality Inspection

Licensee/Titulaire de permis

~~CRAIGLEE NURSING HOME LIMITED~~ CVH (No. 1) LP MC
~~c/o Deloitte & Touche Inc. - 181 Bay Street Brookfield Place, Suite 1400 TORONTO ON M5J 2V1~~ c/o Southbridge Management Services LP-150 Water Street South, SUITE 201 Cambridge, ON N1R 3E2 MC

Long-Term Care Home/Foyer de soins de longue durée

CRAIGLEE NURSING HOME
102 CRAIGLEE DRIVE SCARBOROUGH ON M1N 2M7

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

STELLA NG (507), JOELLE TAILLEFER (211), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 4, 5, 8, 9, 10, 11, 12, 15 & 16, 2014.

The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection (RQI): T- 782-13, T-783-13, T-398-14, T-765-14,
The following Critical Incident Intakes were inspected concurrently with this Resident Quality Inspection (RQI): T- 169-14, T- 470-14, and T-884-14.

During the course of the inspection, the inspector(s) spoke with administrator, social worker (SW), director of care (DOC), assistant director of care (ADOC), registered staff, personal support workers (PSWs), physiotherapist (PT), RAI coordinator, registered dietitian (RD), maintenance supervisor (MS), residents, family members of residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Admission and Discharge
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
0 VPC(s)
0 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right not to be neglected by the licensee or staff is fully respected and promoted.

Interviews with two identified personal support workers (PSW)s indicated that an identified resident requires one-person staff assistance for transferring and toileting.

Interview with the identified resident revealed that on an identified date, the resident was in bed and he/she activated the call bell for assistance to go to the bathroom. He/she waited for approximately two hours before an identified PSW assisted him/her to the bathroom.

Interviews with the first identified PSW confirmed that he/she attended the resident's call in the afternoon on the identified date. The identified PSW indicated that resident said "I think I am soiled". The identified PSW did not provide any care to the resident but told the resident to wait until he/she finished the work in the dining room, and left the resident. Interview with the second identified PSW confirmed that he/she attended the resident's call approximately an hour later, and he/she checked the resident's brief and did not provide care to the resident. The second identified PSW went back to attend the identified resident during the routine resident round an hour later and he/she assisted the resident to the bathroom and changed the brief for the resident. [s. 3. (1) 3.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On an identified date, the inspector observed in an identified resident's room:
1. a TV cable about 8 feet long hanging from the ceiling and reaching the floor by the entrance to the room, and
2. a TV cable about 20 feet long hanging from the ceiling and reaching the floor by the window.

Interview with the maintenance supervisor confirmed that the hanging TV cables are safety hazard.

Four hours later on the same day, the inspector observed the above mentioned TV cables had been removed. [s. 5.]

WN #3: 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. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of the treatment administration record (TAR) indicated that an identified resident's dressing for skin tears is to be changed every two to three days or as frequently as needed. Record review of the TAR for two identified months, and interview with an identified registered staff revealed that the dressing to the skin tears was not changed on an identified date as scheduled.

Interview with the DOC confirmed that the care set out in the resident's plan of care was not provided as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

Record review of the written plan of care for an identified resident revealed that the resident is at moderate risk for falls and has the following falls prevention interventions:
• to ensure that the environment is safe such as the bed is in the low position and personal items are within reach,
• to encourage the resident to ask for assistance as needed, and
• to ensure that the resident is wearing proper footwear at all times.

Interview with an identified PSW confirmed that he/she has been providing direct care to the resident but he/she is not aware of the above mentioned interventions for the resident.

Record review of the written plan of care for a second identified resident revealed that the resident is at high risk for falls and has the following falls prevention interventions:
• to ensure that the environment is safe such as the bed is in the low position and personal items are within reach, and
• to ensure that the resident is wearing proper non-slip footwear at all times.

Interview with an identified PSW confirmed that he/she has been providing direct care to the resident but he/she is not aware of the the above mentioned interventions for the resident. [s. 6. (8)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

Record review revealed that an identified resident has a history of responsive behaviours, and was placed on observation every 30 minutes since an identified date. Record review of the resident's Behaviour Sheet Monitoring records for a period of two and a half months revealed and interview with the DOC confirmed that the above mentioned interventions were not documented for the entire shift for 70 shifts. [s. 6. (9) 1.]

4. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

Review of the progress notes indicated an incident of altercation between two identified residents occurred on an identified date. Review of the first identified resident's written plan of care and interview with an identified registered staff revealed that the written plan

of care for the resident was not revised and up-dated to reflect the resident's responsive behaviour related to the above mentioned incident.

Interview with the DOC confirmed that the written plan of care should reflect the first identified resident's altercation with another resident and the plan of care was not up-dated as required. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff.

On an identified date, the inspector observed that the doors leading to the lift rooms on two identified floors outside an identified elevator were not locked and the areas were not supervised by any staff.

Interview with the DOC confirmed that the above mentioned lift rooms are non-residential areas, the doors of the lift rooms were not locked and they were not supervised by staff to restrict unsupervised access by residents. [s. 9. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

Interview with an identified staff confirmed that a head to toe skin assessment is to be completed within 24 hours after a resident returns from hospital.

Record review revealed and interview with an identified registered staff confirmed that an identified resident was sent to the hospital on an identified date, and returned to the home two days later. A head to toe skin assessment was not completed for the resident upon return from hospital.

Review of the home's policy titled "Head to Toe skin Assessment", policy #: 03-04, effective June 2010, indicates that all residents are to have a Head to Toe Skin Care Assessment completed and documented by a registered staff member upon return from any hospital stay. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Review of the progress notes on an identified date indicated that a skin tear was noted on an identified resident's limb.

Record review revealed and interviews with an identified registered staff and the DOC confirmed that a skin assessment was not completed for the identified resident's skin tear for one month by a member of the registered nursing staff.

The home's policy titled "Wound Care Record" policy #03-09 dated 2010, indicated that the effectiveness of skin or wound treatment will be assessed and evaluated weekly by a member of the registered staff. [s. 50. (2) (b) (iv)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Review of the progress notes on an identified date indicated that an identified resident held a bread knife and threatened that he/she would cut a second identified resident's throat. Interview with an identified registered staff indicated that the residents were separated immediately. Interview with an identified nurse manager revealed that he/she should have been informed immediately of the altercation incident between the residents and further interventions should have been implemented to minimize the risk of altercations between residents as follows:
• Monitor the first identified resident by using the dementia observation sheet (DOS),
• Refer the first identified resident to the behavioural support team,
• Complete the risk management form and,
• Up-date the written plan of care.

Interview with the DOC confirmed that the above interventions were not implemented to minimize the risk of altercations between the residents. [s. 54. (b)]

WN #7: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed, of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

Record review revealed that an identified resident fell on an identified date and was sent to the hospital for assessment for the sustained injuries on the same day.

Record review of the critical incident report indicated that the above mentioned incident was reported to the Director seven days later.

Interview with the DOC confirmed that the home initially reported the incident to the Director by calling the Ministry of Health and Long-Term Care (MOHLTC) after-hours phone number three business days after the occurrence of the incident. [s. 107. (3) 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident under subsection 145 (1), alternatives to discharge have been considered and, where appropriate, tried.

Record review indicated that an identified resident was sent to the hospital on an identified date because of unmanageable responsive behaviours. Interview with the SDM revealed that he/she was not informed about the resident's discharge by the home. Instead, the SDM was informed of the discharge of the resident by the hospital during the resident's stay in hospital.

Interview with the administrator confirmed that the home refused to take the resident back the next day when the resident was ready for discharge from hospital, and the home discharged the resident. Interview with the DOC confirmed that alternatives to discharge have not been considered and tried prior to discharging the resident. [s. 148. (2) (a)]

2. The licensee has failed to ensure that before discharging a resident under subsection 145 (1), the resident's substitute decision-maker (SDM) was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration.

Record review indicated that an identified resident was sent to the hospital on an identified date because of unmanageable responsive behaviours. Interview with the SDM revealed that he/she was not informed about the resident's discharge by the home. Instead, the SDM was informed of the discharge of the resident by the hospital during the resident's stay in hospital.

Interview with the administrator confirmed that the home refused to take the resident back the next day when the resident was ready for discharge from hospital and the home discharged the resident. The administrator also confirmed that the resident's family did not have the opportunity to participate in the discharge planning. [s. 148. (2) (c)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (2) The criminal reference check must be,
(a) conducted by a police force; and O. Reg. 79/10, s. 215 (2).
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. O. Reg. 79/10, s. 215 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a criminal reference check is conducted within six months before a staff member is hired.

Review of the record of employment of an identified PSW and interview with the DOC confirmed that the identified PSW was hired for a period of 20 months and a criminal reference check was not conducted. [s. 215. (2) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

On an identified date, the inspector observed respiratory isolation signage posted on an identified resident's door. The inspector observed an identified registered staff talking to the resident at bedside.

Interview with the identified staff confirmed that personal protection equipment (PPE) should have been worn before entering the resident's room.

Interview with the DOC confirmed that the identified registered staff should have donned the PPE prior to entering the isolation room. [s. 229. (4)]

Issued on this 7th day of January, 2015

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

Original report signed by the inspector.