



**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  
prévus 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  
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<b>Date(s) of inspection/Date(s) de l'inspection</b>	<b>Inspection No/ No de l'inspection</b>	<b>Type of Inspection/Genre d'inspection</b>
Nov 7, 8, 28, 30, Dec 1, 5, 6, 20, 2011	2011_021111_0035	Critical Incident

**Licensee/Titulaire de permis**

CRAIGLEE NURSING HOME LIMITED  
c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1

**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**

LYNDA BROWN (111)

**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 the Administrator, the Director of Care(DOC), three Registered Practical Nurses(RPN),one Personal Support Worker (PSW) and two residents.

During the course of the inspection, the inspector(s) Related to log # O-003030-10 & O-001829-11 observed three residents, reviewed health records of three residents, and reviewed homes records.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Hospitalization and Death

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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.)	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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following subsections:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
- 4. Misuse or misappropriation of a resident's money.**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. Log # O-001829-11

-Critical Incident Report (CI) (#2503-000025-11) indicates a cognitive resident assaulted a cognitively impaired resident who sustained injury and no verbal report was made to the Director related to the CI until the CI was submitted two days later.

**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 the licensee who has reasonable grounds to suspect that abuse or a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident is immediately reported to the Director, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
  2. Cognition ability.
  3. Communication abilities, including hearing and language.
  4. Vision.
  5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
  6. Psychological well-being.
  7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
  8. Continence, including bladder and bowel elimination.
  9. Disease diagnosis.
  10. Health conditions, including allergies, pain, risk of falls and other special needs.
  11. Seasonal risk relating to hot weather.
  12. Dental and oral status, including oral hygiene.
  13. Nutritional status, including height, weight and any risks relating to nutrition care.
  14. Hydration status and any risks relating to hydration.
  15. Skin condition, including altered skin integrity and foot conditions.
  16. Activity patterns and pursuits.
  17. Drugs and treatments.
  18. Special treatments and interventions.
  19. Safety risks.
  20. Nausea and vomiting.
  21. Sleep patterns and preferences.
  22. Cultural, spiritual and religious preferences and age-related needs and preferences.
  23. Potential for discharge. O. Reg. 79/10, s. 26 (3).
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**Findings/Faits saillants :**

1. log # O-001829-11

An identified, cognitive resident at risk for aggressive behaviours did not indicate in the plan of care what the behaviours were or the triggers.

2. An identified, cognitively impaired resident at risk for injury related to inappropriate behaviours did not indicate in the plan of care what the behaviours were or the triggers.

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

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**Findings/Faits saillants :**

1. Log # O-001829-11

Critical Incident Report (CI) (#2503-000025-11) indicates a cognitive resident assaulted a cognitively impaired resident who sustained injury and there was no indication an investigation occurred.

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

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**Findings/Faits saillants :**

1. Log # O-001829-11

Critical Incident Report (CI) (#2503-000025-11) indicated a cognitive resident assaulted a cognitively impaired resident who sustained injury and there was no indication the home contacted the police.

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***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 any alleged, suspected or witnessed incidents of abuse that the licensee suspects may constitute a criminal offence are immediately reported to the appropriate police force, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

Specifically failed to comply with the following subsections:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) 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:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
  - i. names of any residents involved in the incident,
  - ii. names of any staff members or other persons who were present at or discovered the incident, and
  - iii. names of staff members who responded or are responding 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.
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.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

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**Findings/Faits saillants :**

1. log # O-001829-11

Critical Incident Report (CI) (#2503-000025-11) indicates a cognitive resident physically assaulted another cognitively impaired resident who sustained injury. There was no indication on the CI the physician was notified. There was no indication on the CI which family member was notified. (ref.s.107(4)3.ii, iv)

Issued on this 20th day of December, 2011

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