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
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 19, 23, Apr 24, 27, 30, May 1, 2012	2012_048175_0005	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

BRENDA THOMPSON (175)

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 Care, Assistant Director of Care (ADOC), Two Registered Nurses(RN), Two Registered Practical Nurses (RPN), Maintenance Services Person

During the course of the inspection, the inspector(s) reviewed Critical Incident Report, resident #2 health record specific to the Critical Incident, The home's Report of Elopement Incident, Policy & Procedures specific to the incident, Maintenance Request Log, Purchase Order from Exclusive Alarms Fire & Security Systems, Morning Report- Managers,24 Hour Shift Report Summary , Shipping Invoice from Resident Nurse Alert Technology for Service & Equipment.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

Safe and Secure Home

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following subsections:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. Critical Incident submitted to the Ministry of Health and Long Term Care indicated resident #2 has extreme behavioural problems, is constantly wandering and exit seeking.Resident eloped and was found outside the building.

2.Care Plan reviewed and indicated resident #2 is constantly wandering and exit seeking. Resident is capable to open door and push it to go outside.

3.Resident's record review indicated resident #2 eloped from the home through a resident accessible stairwell door, was found outside the home and was hospitalized as a result of the incident. Nursing progress notes reviewed, indicated the resident did push open the same door, the day before the incident and three days after the incident.

4.Elopement Incident Notes reviewed and indicated at the same time of the search for resident #2, another resident(#4) was also found following the staff and went through the door twice.

5.Interview with Maintenance Person indicated if there is a maintenance issue in the home the staff put it in the log book kept at the nursing station and it is checked every morning. If there is an emergency, the staff call me at home. We also have a Management meeting every morning where we talk about any problems. I did not receive a call at home for the elopement of resident #2. I heard of the incident when I came in the following morning.

6.Maintenance Request Log reviewed and indicated no entries related to doors, for the dates nursing progress notes indicated the resident #2 was able to open a side exit door. Entry for the date of elopement indicated that the identified exit door was not properly locked.

8.Purchase Order to the home from Cimtel Telecommunications, indicated 1 Repair Key Pad, Mag Lock Issue, Replace Power Supply.

The licensee failed to ensure an identified resident accessible door leading from the corridor to the stairwell, is kept closed and locked at all times.

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

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 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 subsections:

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.A Critical Incident submitted by the home to the Ministry of Health and Long Term Care indicated resident #2 is constantly wandering and exit seeking. The identified resident eloped through a resident accessible stairwell door and was found outside the building. The door leading from the nursing unit unit to the stairwell is controlled by a mag lock. Resident #2 was hospitalized as a result of the incident.

2.Nursing progress notes reviewed, indicated the resident did push open the same door, the day before and three days after the incident. The resident's plan of care was not reviewed and revised before or after the incident of elopement to include interventions to ensure the resident could not continue to push open the exit door and elope from the home.

3.Geriatric Health Outreach Team notes 2 days after the incident were reviewed and indicated :Staff report client eloped and was found outside.
Suggest 1- applying wander guard bracelet
applying large wander barrier at the identified exit door
15 minute observations. The resident's plan of care was not revised to include these suggested recommendations.

4.Care Plan by Physio was reviewed and indicated there was no Physio assessment or recommended interventions to assess/manage the resident #2's changes in mobility.

The licensee failed to ensure that resident #2 was assessed and the plan of care was reviewed and revised when the resident's care needs changed. (Ref. s.6(10)(b)).

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 the resident is assessed and the plan of care is reviewed and revised whenever the resident's care needs change, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. Review of the resident care plan indicates resident #2 is constantly on the floor, exit seeking, capable to open exit door.
Interventions include monitor behaviour episodes and attempt to determine underlying causes, provide concise explanations of care and treatment to resident prior to initiating, provide flexibility in daily routine to accomodate resident, monitor by one Personal Support Worker. Distract or re-direct resident approach after 15 minutes if refuses care.

2.Physio Assessment reviewed did not include any assessment of changes to the resident's mobility or interventions implemented for management of same.

3.Nursing Progress Notes were reviewed and indicated resident #2 was identified with changes to mobility status from November 2011 and continued to January 2012, where resident #2 was found wandering in the basement, seeking exit.

4.Resident #2 eloped from the home through a resident accessible stairwell door, was found outside the home and was hospitalized as a result of the incident. Nursing progress notes reviewed, indicated the resident did push open the same door, the day before the incident and three days after the incident.

The licensee failed to ensure the plan of care was based on, at a minimum, interdisciplinary assessment of the resident's mood and behaviour patterns, including wandering, any potential behavioural triggers and variations in resident functioning at different times of the day.(Ref. r.26(3)5).

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 every resident's plan of care related to responsive behaviours is based on, at a minimum,interdisciplinary assessment of 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., to be implemented voluntarily.

Issued on this 2nd day of May, 2012

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BRENDA THOMPSON (175)
Inspection No. / No de l'inspection :	2012_048175_0005
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Mar 19, 23, Apr 24, 27, 30, May 1, 2012
Licensee / Titulaire de permis :	CRAIGLEE NURSING HOME LIMITED c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1
LTC Home / Foyer de SLD :	CRAIGLEE NURSING HOME 102 CRAIGLEE DRIVE, SCARBOROUGH, ON, M1N-2M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANGIE HEINZ

To CRAIGLEE NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 901

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
   i. kept closed and locked,
   ii. equipped with a door access control system that is kept on at all times, and
   iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
      A. is connected to the resident-staff communication and response system, or
      B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Order / Ordre :

The licensee will ensure that the resident accessible door leading from the corridor to the stairwell on Nursing Unit 1 West, is kept closed and locked at all times.

Grounds / Motifs :

1. Critical Incident submitted by the home to the Ministry of Health and Long Term Care indicated resident #2 eloped and was found outside the building.

2.Care Plan reviewed and indicated resident #2 is constantly wandering and exit seeking. Resident is capable to push open exit door.

3.Resident #2's record review indicated the resident eloped from the home through a resident accessible stairwell door, was found outside the home and was hospitalized as a result of the incident. Nursing progress notes reviewed, indicated the resident did push open the same door, the day before and three days after the incident.

4.At the same time of the search for resident #2, another resident(#4) was also found following the staff and went through the same door twice.

5.Interview with Maintenance Person indicated that if there is a maintenance issue in the home, the staff put it in the log book kept at the nursing station and it is checked every morning. If there is an emergency, the staff call me at home. I did not receive a call at home for the elopement of resident #2.

6.Maintenance Request Log reviewed and indicated no entries related to doors, on identified dates except for the date of elopement.

7.Purchase Order to the home from Cimtel Telecommunications, indicated 1 Repair Key Pad, Mag Lock Issue, Replace Power Supply for identified door.

The licensee failed to ensure an identified resident accessible door leading from the corridor to the stairwell, is kept closed and locked at all times. (s. 9 (1) i). (175)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 01, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 1st day of May, 2012

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BRENDA THOMPSON

Service Area Office /
Bureau régional de services : Ottawa Service Area Office