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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Dec 5, 2016	2016_377502_0015	027683-16	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (no.1) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

JULIENNE NGONLOGA (502), JOANNE ZAHUR (589), JULIEANN HING (649)

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): September 15, 16, 20, 21, 22, 23, 26, 27, 28, 29 and 30, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physician, Director of Care Clerk Scheduler, Resident Assessment Instrument - Minimum Data Set (RAI MDS) Coordinator, Programs Coordinator/ Acting Social Worker, Dietary Manager, Registered Dietitian, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents' Council President, Family Council President, residents, and family members.

The inspectors conducted an initial tour of the home, observed the provision of care, staff to resident interactions, medication administration; reviewed residents' health records, staffing schedules, staff employment records, training records, Resident and Family Councils meeting minutes, relevant policies and procedures.

During the course of the inspection, the following complaints intakes were inspected:
- 007242-15 related to wrongful discharge
- 026470-15 related to skin and wound care
- 010963-15 related to fall prevention
- 023208-15 related to responsive behaviour
- 029890-15 related to Resident's Bill of Rights
- 029886-15 related to staff to resident abuse
- 024788-16 related to drugs administration
- 006247-16 related to related to resident to resident abuse

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
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.

- **7 WN(s)**
- **5 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 there is a written plan of care that sets out the planned care for resident #022.

On an identified date, a Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term (MOHLTC) related to an alleged incident of physical abuse between resident #022 and resident #023 that had occurred on the same day, which resulted in injury to resident #023.

Record review of resident #022's most recent written plan of care revealed that resident #022 had been demonstrating responsive behaviours. Further review of the resident's most recent written plan of care failed to reveal that behavioural triggers had been associated with the above identified responsive behaviours.

In interviews, staff #103 and staff #114 stated that other behavioural triggers had been identified for resident #022. Staff #103 further stated that these additional behavioural triggers had not been included in the written plan of care.

In an interview, staff #113 who is also the co-chair for the Responsive Behaviour program in the home, confirmed that behavioural triggers had not been identified in resident #022's written plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

On an identified date, a CIS report was submitted to the MOHLTC related to an alleged incident of physical abuse between resident #022 and resident #023 that had occurred on the same day, which resulted in injury to resident #023.

Review of resident #022's progress notes revealed on an identified date, staff #121 had assessed, reviewed, and adjusted resident #022's medication. There was no indication that an assessment had been completed related to the above identified incident of physical abuse between residents #022 and #023 on the above identified date.

Staff #103 in an interview stated he/she had noted the above mentioned incident in the Weekly Problem List Form located in the physician's binder. Staff #103 also stated that staff #121 had retrieved the Weekly Problem List Form and the home had not kept a copy.

Staff #121 in an interview stated that he/she had not been notified of the above mentioned incident between resident's #022 and #023 on the Weekly Problem List form. Staff #121 further stated that if he/she had been aware of the incident, he/she would not have started tapering down resident #022's identified medication.

Staff #104 who is also the Behavioural Support Ontario (BSO) chair in the home in an

interview stated that when incidents of resident responsive behaviours occur, the nursing staff are to send a referral to him/her. Staff #104 further stated he /she had not received a referral for the above mentioned incident between resident #022 and #023.

Staff #106 in an interview confirmed that the nursing staff had failed to collaborate with staff #121 and staff #104 in the assessment of resident #022 so that assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

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

On an identified date MOHLTC Action-Line received a complaint related to the care of the resident in the home. The complainant stated that resident #012 had not been provided with specified care since his/her admission, on an identified date, which was ten days prior

Review of resident #012's written plan of care with an identified date revealed the resident #012's identified care was scheduled twice weekly.

Record review of care provided to resident #012 during the identified period of time revealed that resident #012 was provided with the identified care 10 days after his/her admission into the home. Further review failed to revealed documentation to indicate that resident #012 received the identified care as per resident plan of care.

Staff #134, staff #137 and staff #103 in interviews stated that resident #012 had declined the identified care on admission. Staff interviews indicated the care had not been documented because of a shortage of staff.

Staff #103 and staff #102 in interviews confirmed that resident #012 had been provided with the identified care as per the identified care schedule, and stated that staff should document all care that had been provided to the resident. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary.

The MOHLTC Action-Line received a complaint that resident #001's identified medial assistive device had not been changed as required for an an identified period of time.

A review of resident #001's progress notes indicated that the identified resident's medical assistive device had been discontinued on a specified date as per physician order. A review of resident #001's written plan of care dated approximately three weeks after the discontinuation of the identified medical assistive device revealed that the written plan of care had not been revised to reflect resident #001's change in care needs.

During an interview with staff #103 and #110, they confirmed that resident #001 had not been reassessed after there was a change in his/her continence care needs and the written care plan was not reviewed and revised to reflect the change in resident's #001's continence care needs. Staff #113 confirmed that the resident should have been immediately reassessed after the medical assistive device was removed and the care plan should have been revised and updated. [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:
- there is a written plan of care that sets out the planned care for resident #022,
- staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
- the provision of the care set out in the plan of care is documented, and
- the resident is reassessed and the plan of care reviewed and revised any other time when the resident's care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's Responsive Behaviours policy was complied with.

Review of the home's Responsive Behaviours policy #09-05-01 dated September 2010, revealed that staff are responsible for completing accurate documentation in the resident's health record when behaviour had been observed. The documentation should clearly describe the following:
- any identified triggers,
- how the behaviour was displayed,
- what was observed in the immediate surroundings,
- what interventions were tried, what interventions were unsuccessful or successful,
- additional actions taken by the staff or others and,
- any negative experience or outcome for the resident or another person/resident.

On an identified dated a CIS report was submitted to the MOHLTC related to resident to resident physical abuse.

Review of the CIS report revealed that on a specified date, resident #022 had been seated outside resident #023's room when resident #023 came out of his/her room with his/her mobility device, and he/she accidentally hit resident #022. Resident #022 then stood up and struck resident #023, which resulted in an injury to resident #023

Record review of progress notes for resident #022 revealed that the above mentioned incident had not been documented in either the progress notes or under risk management in the home's documentation system.

In an interview with staff #103 , stated that he/she thought the above incident had been documented; however, a review of the progress notes for the identified date of the incident revealed there had been no entry related to the above identified incident between residents #022 and #023. Staff #113 confirmed staff #103 had not complied with the home's Responsive Behaviour policy related to documentation. [s. 8. (1) (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 the home's Responsive Behaviours policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone.

During an interview with resident #004, the inspector became aware of an allegation of staff to resident abuse. Resident #004 stated that staff #122 verbally and physically abused him. Resident #004 stated that he/she feels afraid of staff #122 as he/she is unsure how the staff #122 will react. The resident also stated that he/she had not reported the above incidents to the home and had been unable to recall when these incidents had occurred.

A review of staff #122's personal file revealed multi-disciplinary actions had been taken for an identified period of time.

In an interview, staff #122confirmed providing care to resident #004, however denied the above allegations of abuse. Staff #122 stated that he/she speaks loudly and that is the natural tone of his/her voice.

In an interview with staff #103, he/she stated that staff #122 speaks loudly and the other staffs have had to remind the staff#103 to reduce the tone of his/her voice.

Interview with staff #106 confirmed that the above mentioned incidents constitute actions of abuse and staff #140 stated that staff #122 had been suspended since the home became aware of the incident. [s. 19. (1)]

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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: 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,
(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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

A complaint was received by MOHLTC regarding skin breakdown related to neglect of care.

Review of resident #001's progress notes revealed that he/she was admitted to the home with altered skin integrity Review of resident #001's weekly skin and wound assessment records for an identified period of time revealed weekly skin and wound assessments had not been completed as required an identified period of time.

In an interview with staff #113, he/she stated that nursing staff should complete the weekly skin and wound assessment on any resident with altered skin integrity and confirmed that resident #001's skin and wound assessments had not been completed on the above identified period of time. [s. 50. (2) (b) (iv)]

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 a 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, to be implemented voluntarily.

WN #5: 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 participate in the implementation of the infection prevention and control program.

On an identified date, observations conducted during stage one of the Resident Quality Inspection (RQI) by inspectors #589 and #649 revealed unlabeled personal items in a shared bathroom.

In an interview with staff #101, he/she stated that residents sharing a common bathroom should have all of their personal items labeled to prevent risk of transmission of infection.

In an interview, staff #100, stated that it is the home's expectation that when residents share a common bathroom all personal items are to be labeled to prevent risk of transmission of infection.

In an interview with staff #106, he/she confirmed that staff had not participated in the implementation of the infection prevention and control program when resident's personal items in a shared bathroom were not labeled. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program by lebeling residents' personal items, to be implemented voluntarily.

WN #6: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity is fully respected and promoted.

During an interview resident #002 told the inspector that staff had not been respectful of him/her, and that staff go through his/her drawers and throw away identified belongings.

In an interview, staff #115stated that staff were directed by staff #104 to check and clean resident #002's drawers while he/she was not in the room as he/she was not agreeable to them checking his/her belonging. RPN #115 also stated that when the staff checked and cleaned the resident's drawers as directed, the resident had gotten very upset.

Review of resident #002's most recent written plan of care failed to indicate that the above interventions had been discussed with the resident.

In interviews, staff #104 and staff #113 confirmed that resident #002 had not been informed about the above decision, because he/she would had never consent to staff checking and cleaning the drawers. Staff #113 stated that resident #002 had not been treated with respect as he/she had not been informed prior to staff searching the drawers. [s. 3. (1) 1.]

WN #7: 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) the licensee shall ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken.

On a specified date, a CIS report was submitted to the MOHLTC, and the MOHLTC Action-Line received a complaint related to a wrongful discharge one day after.

Review of the CIS report, the complaint letter, and resident #010's progress notes revealed that on an identified date and time, the resident was found exhibiting an identified responsive behaviour in his/her room; this had been an ongoing behaviour. The next day, at an identified time, the resident was discharged and transferred to an identified home. Resident #010's upset family member brought the resident back to the home and the resident was readmitted.

Interview with staff #104 stated that resident #010 had been told on multiple occasions of the potential risks that his/her identified responsive behaviour was a safety risk for all the residents in the home. On an identified date resident #010 told the Administrator that he/she did not care if he/she had put the home at a safety risk. At that point, staff #140 directed staff #104 to find a place where resident #010 would be transferred. On an identified date, an unidentified staff agreeded to admit resident #010.Staff #104 stated that once the arrangement had been made, he/she informed the resident and his/her family's member about the resident's transfer. On the same day, the resident was given his/her belongings and medication, and then transferred to an identified home.

In an interview, staff #140 confirmed that resident #010 nor the resident's SDM was not informed and given the opportunity to participate in the discharge planning and his/her wishes are taken into consideration. [s. 148. (2)]

Issued on this 4th day of January, 2017

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

Original report signed by the inspector.