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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 3, 2017	2017_630589_0014	031988-16, 032495-16, 034779-16, 004103-17, 005784-17	Complaint

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

JOANNE ZAHUR (589)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 22, 23, 24, 25, 28, 29, and 30, 2017.

The following critical incident report was inspected during this inspection: log #004103-17/CIS #2503-000006-17 related to prevention of abuse/neglect and plan of care.

The following complaints were inspected during this inspection: log #031988-16, log #032495-16, log #034779-16, and log #005784-17 related to plan of care, prevention of abuse and neglect, skin and wound, and dining and snack service.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Nurse Managers (NMs), consulting Pharmacist, Toronto Police Services Detective, and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of medication administration system, staff and resident interactions and the provision of care, record review of health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **3 WN(s)**
- **2 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Complaints were received by the Ministry of Health and Long Term Care (MOHLTC) which involved multiple areas of care related to resident #026. A critical incident system report was also submitted related to alleged staff to resident neglect involving resident #026.

A review of resident #026's written plan of care upon admission to home revealed resident ambulated independently within his/her room with the aid of a mobility aid, an alternate mobility aid was required for long distances, and was able to ambulate independently requiring one staff limited assistance with continence care needs.

A review of progress notes revealed resident #026 experienced an incident that resulted in an injury. Upon re-admission to the long term care home (LTCH) resident #026 required increased assistance with his/her care needs.

In an interview, staff #133 stated resident #026 was re-admitted to the LTCH after a medical procedure had been completed that restricted his/her mobility and now as a result all transfers required the use of a transfer apparatus with two staff assistance, and the use of a mobility aid for short and long distances. Staff #133 further stated resident #026 was restricted to bed related to a change in his/her weight bearing status.

A review of the written plan of care completed post re-admission from hospital did not reveal the above mentioned changes to his/her ADL care needs.

In an interview, staff #141 stated resident #026's written plan of care had not been updated to reflect his/her increased ADL care needs after an incident with injury.

In an interview, staff #113 acknowledged the home had failed to ensure that the written plan of care had set out the planned care for resident #026 post an incident that had resulted in a change of care need levels. [s. 6. (1) (a)]

2. The licensee had failed to ensure that the resident’s substitute decision maker (SDM), if any, and any other persons designated by the resident or SDM are given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

Complaints were received by the Ministry of Health and Long Term Care (MOHLTC) which involved multiple areas of care related to resident #026. A critical incident system report was also submitted related to alleged staff to resident neglect involving resident #026.

In an interview, family member #200 stated the home was not monitoring and managing resident #026's identified health condition.

A review of resident #026’s electronic medication administration record (e-MAR) revealed monitoring was being completed routinely at specified times throughout the day and that medication related to this underlying health condition was being administered at specified times throughout the day as well.

A review of the physician’s orders revealed the physician had made changes to resident #026s medication doses on five occasions.

A review of resident #026's progress notes over a 4 month period did not reveal any registered staff documentation that family member #200 had been notified of the above mentioned changes in resident #026's medication doses.

In an interview, staff #141 stated that family member #200 had not been informed when the physician had made changes to resident #026’s medication dosages to manage an

underlying health condition and therefore resident #026's family member was not provided an opportunity to participate in the development and implementation of the care plan.

In an interview, staff #144 stated he/she thought whenever there were any medication changes with a resident, the registered staff would call family to inform them of the change(s). Staff #144 further stated that he/she had not been aware that registered staff had not called family member #200 with any medication changes for resident #026.

In an interview, staff #113 stated it is the home's expectation that registered staff transcribing physician orders with either new medications or changes in the dosage of an existing medication are to call the resident's family to inform them and obtain consent if that is required. Staff #113 acknowledged that staff had failed to inform resident #026's family member of changes in medication dosages and therefore had not provided an opportunity for resident #026's family member to participate fully in the development and implementation of the resident's plan of care related to the management of an underlying health condition. [s. 6. (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 that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Complaints were received by the Ministry of Health and Long Term Care (MOHLTC) which involved multiple areas of care related to resident #026. A critical incident system report was also submitted related to alleged staff to resident neglect involving resident #026.

In an interview, family member #200 stated a nurse at the home had independently decided to stop administering an identified medication to resident #026 after re-admission to the home after a medical absence.

A review of resident #026's discharge form from the medical absence revealed an existing identified medication had been discontinued by health practitioners during the medical absence and that an alternate medication was prescribed to be initiated as per the prescriber's instructions. Resident #026 was to receive a specific number of doses of this identified medication.

Review of resident #026's e-MAR revealed the above mentioned medication had been initiated on an identified date in November 2016, at a specific time in the evening and was discontinued on an identified date in November 2016, midday. Further review of the e-MAR revealed resident #026 had not the full amount of doses as per the prescriber's direction.

In an interview, staff #141 stated resident #026 had not received the total number of doses of the above mentioned prescribed medication. Staff #141 further stated the order had been transcribed to be administered for an identified number of days however the time of when the first dose was administered had not been considered when indicating the stop date on the e-MAR.

In an interview, staff #113 acknowledged that staff had failed to ensure the above mentioned medication had been administered to resident #026 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her SDM.

Complaints were received by the Ministry of Health and Long Term Care (MOHLTC) which involved multiple areas of care related to resident #026.

The sample size of residents to inspect this item was expanded to three residents as a result of non-compliances identified in the initial resident.

In an interview, family member #200 revealed concerns related to how the home's staff

were managing resident #026's health conditions and medication administration. Family member also revealed that the physician was not present at the admission conference and therefore resident #026's medical conditions had not been clearly discussed. Family member #200 further revealed attempts to talk to the physician on his/her visit days in the home were difficult to arrange as most of the time the physician was too busy to have the time required to discuss their concerns.

Review of the home’s policy titled Care Assessment and Planning-Interdisciplinary Team Conference: Organizing Guidelines, policy number RESI-03-01-03, reviewed December 2002 revealed the following on page of three under communication:
-that all members including the resident and family should be aware of the purpose of the conference,
-all data regarding medical diagnosis, social history, strengths, interests, previous lifestyle, care preferences, functional ability, coping strategies, and support systems, as well as holistic needs and problems should be presented, and
-resident goals should be established which are realistic, precise, measurable, timed, clearly defined and mutually agreed upon and supported.
On page two of the above mentioned policy under conference procedure the duties of each member of the interdisciplinary team are outlined, specifically, point number three addresses the role of the physician who is to review medical history/concerns.

Review of point click care (PCC) under the assessment tab revealed that the primary physician was not present for care conferences held for residents #019 and #032 after their admission, respectively.

In an interview, staff #144 stated primary physicians do not attend admission nor annual care conferences for residents that reside in the home.

In an interview, staff #129 who also coordinates all care conferences in the home stated that primary physicians attending care conferences has not been a practice in the home. Staff #129 further stated that physicians are considered part of the interdisciplinary team and therefore should be present at care conferences. Staff #129 also stated beginning September 2017, the home is moving forward in booking admission care conferences with physicians present.

Staff #129 acknowledged the home had failed to conduct care conference consisting of the interdisciplinary team which also included the home’s physicians. [s. 27. (1)]

Issued on this 5th day of October, 2017

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

Original report signed by the inspector.