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
Feb 26, 2018	2018_646618_0004	016701-17	Complaint

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes 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

CECILIA FULTON (618)

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): January 18, 19, 22, and 23, 2018.

This Inspection was initiated to conduct an inspection of issues identified in complaint log #016701-17 related to medication administration and following plan of care.

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator, Physiotherapist (PT), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and resident's Substitute Decision Maker (SDM).

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care and medication administration and reviewed clinical health records.

The following Inspection Protocols were used during this inspection:
Medication
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
1 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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an identified intervention was included in the resident's plan of care.

This inspection was initiated due to a complaint that staff had damaged an identified restraint used for resident #001.

Interview with the resident's Substitute Decision Maker (SDM) revealed that at some point during the resident's time in the facility, the resident's identified restraint was damaged by staff.

This inspection was unable to determine that this item was damaged, however in the course of inspecting this issue, it was revealed the identified restraint and another identified intervention were not included in resident #001's plan of care.

Review of the admission Minimum Data Set (MDS), dated June 2017, assessment did not include any mention of the identified restraint or intervention.

Chart review revealed that resident #001's Substitute Decision Maker (SDM) had signed a consent for the identified restraint.

Record review revealed that a conversation between resident #001's SDM and a staff member on duty, where they discussed the use of the identified restraint and the indication for it's use.

Review of a Physiotherapy (PT) referral note of June 2017, mentioned that resident #001

was using the identified restraint.

Interview conducted with the PT revealed that the identified restraint was to be used for resident #001 because of identified risk factors. The PT revealed that this restraint should have been included in the resident's plan of care.

Interview with PSW #114 revealed that they recalled that the identified restraint and intervention was used for resident #001 and that at some point the restraint was no longer being used due to an identified reason. PSW #114 revealed that where the identified restraint is being used, that information would be included in the resident's plan of care and that the use of this restraint would require documentation in Point of Care (POC).

Interview with PSW #110, revealed that they recall that the identified restraint was used and they recall the resident's SDM mentioning something about it, but PSW #110 could not recall any details related to the use of the restraint.

Interview with registered staff #111 revealed that they did not recall the specifics of the identified restraint.

Review of the plan of care did not include the identified restraint for resident #001. [s. 31. (1)]

2. The licensee has failed to ensure that there is an order by either the physician or the registered nurse in the extended class for the use of restraints.

Record review and staff interviews revealed that and identified restraint was used for resident #001.

Chart review and information provided by the assistant Executive Director revealed that there was no physician or registered nurse in the extended class order written for the use of any restraint. [s. 31. (2) 4.]

Issued on this 6th day of March, 2018

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

Original report signed by the inspector.