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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 4, 2019	2019_630589_0002	032373-18, 032660-18	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

JOANNE ZAHUR (589), SUSAN SEMEREDY (501)

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 10, 11, 14, 15, 16, 17, 18, 21, 22, and 23, 2019.

The following complaints were inspected:
Log #032373-18, and #032660-18 related to skin and wound care, plan of care, weight loss and nutrition, and unlawful discharge from the home.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Acting Director of Care (A-DOC), Nurse Managers (NM), Registered Dietitian (RD), Physician, Personal Support Workers (PSW), Registered Staff (RN/RPN), Enterostomal Therapist-Nurse (ET-N), Social Worker (SW), Resident Assessment Instrument-Minimum Data Set-Coordinator (RAI-MDS-C), Local Health Integration Network-Case Manager (LHIN-CM), residents, family members, and substitute decision makers (SDM).

During the course of the inspection, the inspector(s) observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed health records, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Nutrition and Hydration
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was provided to the resident as specified in the plan.

During an interview, resident #001's family member indicated they were concerned about the health and nutritional status of resident #001.

A review of resident #001's physician's orders indicated an identified nutritional supplement had been ordered. A progress note in November 2018, written by staff #131 indicated they had tried to reach resident #001's family member regarding altering the nutritional supplement however, they had been unable to reach the family member but would follow up.

A review of a progress note from December 2018, after the resident had been transferred to the hospital, revealed the home had provided the family member with a box of an identified nutritional supplement to take with them to the hospital. According to the note written by staff #131, the family member showed the home a picture they had taken of the resident while in hospital that indicated the nutritional supplement in place. The picture indicated an identified nutritional supplement however the label stated the type of another nutritional supplement. Staff #131 took back the box from the family member prior to them leaving the home and replaced it with the ordered nutritional supplement and informed the management of the home of the discrepancy. As a result of the above mentioned incident, the ADOC initiated an incident report.

During an interview, staff #131 explained that even though there had been a discussion about changing resident #001's nutritional supplement, nothing had been decided or processed. According to staff #131, there were no negative consequences from the resident receiving an alternate nutritional supplement.

During an interview, staff #101 stated they had investigated the above mentioned incident. When resident #001 was transferred to hospital the nutritional supplement they had been receiving went with them. This nutritional supplement had been initiated by an identified night registered staff and had been done so in error.

During an interview, staff #134 acknowledged giving resident #001's family member what they had requested and further stated they were aware of the nutritional supplement resident #001 should have been receiving but had received approval from various managers to give the family member what they were requesting. The staff member admitted they documented giving the nutritional supplement to the family but failed to describe the discrepancy.

During an interview, staff #101 acknowledged the night nurse had made an error and that staff #134 should not have given the family member a box of nutritional supplement that had not been specified in the plan of care. [s. 6. (7)]

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 plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Related to non-compliances under O. Reg., 79/10, r. 30 (2) under skin and wound for resident #001, the scope of the inspection was increased to include resident #017.

A review of resident #017's current care plan under the altered skin integrity focus indicated they had an area of altered skin integrity and an intervention in place required they be turned and repositioned every two hours (q2h). A review of the tasks tab in point click care (PCC), the home's electronic documentation system indicated the intervention of turning and repositioning resident #017 q2h had not been entered as a documentation task to be completed by the personal support worker (PSW). A review of the point of care (POC) failed to reveal documentation that resident #017 had been turned and

repositioned q2h by their assigned PSW.

During an interview, PSW #135 stated they usually are required to document in the POC under the tasks tab when a resident is turned and repositioned q2h however, for resident #017 they had not been documenting that this intervention was being completed.

During an interview, staff #101 stated since resident #017 had an area of altered skin integrity they would be under the skin and wound program in the home. Staff #101 also stated that whomever had updated the care plan with this intervention should have initiated as a task in the POC enabling the PSWs to document this intervention.

The staff member who had updated resident #017's care plan with the above mentioned intervention no longer works in the home therefore, an interview was not conducted.

Staff #101 acknowledged the home had failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions was documented. [s. 30. (2)]

2. Interviews with resident #001's family members indicated that the home had not provided proper care for the resident's altered skin integrity and, as a result, the resident required a surgical procedure.

A review of resident #001's health record indicated the home documented that the resident had an area of altered skin integrity on an identified date in September 2018. Weekly wound assessments were completed and this altered skin integrity remained clean and dry. A weekly wound assessment dated in November 2018, indicated this altered skin integrity had deteriorated.

During an interview, staff #129 recalled seeing resident #001's area of altered skin integrity on an identified date in November 2018, and had been concerned at that time. Staff #129 remembered telling staff #134 who then applied a treatment intervention to the area.

A review of resident #001's health record and the home's 24 hour shift reports for two identified dates in November 2018, failed to indicate staff #134 had documented the change in resident #001's skin integrity and what treatment interventions were implemented. During an interview, staff #134 recalled applying a treatment intervention but realized they should have documented their assessment and treatment interventions.

A review of resident #001's most recent plan of care indicated staff are to turn and reposition resident #001 q2h and as needed. A review of the POC failed to reveal documentation that resident #001 had been turned and repositioned q2h by their assigned PSW. Interviews with staff #124, #129 and #130 indicated they had repositioned resident #001 q2h but could not recall if they had documented this intervention or not. During an interview, staff #124 showed the inspector how for some residents they have the ability to document turning and repositioning on their POC.

During an interview, staff #128 confirmed that turning and repositioning resident #001 q2h had not been assigned as a task in the POC for PSWs to document. Staff #128 confirmed that this should have been done by the registered staff when creating the intervention in the plan of care. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 73. Staff qualifications
Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,
(a) have the proper skills and qualifications to perform their duties; and
(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Findings/Faits saillants :

The licensee had failed to ensure that that all staff of the home have the proper skills and qualifications to perform their duties.

During an interview, resident #001's SDM indicated they were concerned about the level of care being provided at the home.

During an interview, staff #101 stated that since joining the home in July 2018, they had held four different positions, most recently as the Acting-DOC.

Staff #101 stated that when they were the ADOC, they were also the skin and wound care lead. They stated that during that time they had told the previous DOC they were uncomfortable with being the skin and wound lead as they had little experience in the area, needed additional education, and more support from an RN, perhaps the assistant director of care (ADOC) or nurse manager (NM).

According to staff #101, no additional skin and wound education was found for them to pursue and they learned mostly from the ET-N who is contracted to the home to come once a month. Staff #101 did not feel the home would provide any education for skin and wound that would entail a cost.

During an interview, staff #100 acknowledged that staff of the home may not have the proper skills and qualifications to perform their duties. [s. 73. (a)]

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 that all staff of the home have the proper skills and qualifications to perform their duties, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 144. No licensee of a long-term care home shall discharge a resident from the long-term care home unless permitted or required to do so by this Regulation. O. Reg. 79/10, s. 144.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a licensee has discharged a resident from the long-term care home, they did so for the reasons permitted or required by the Regulation.

O. Reg. 79/10, s. 145 states:
(3) A licensee of a long-term care home may discharge a resident if,
(a) the resident decides to leave the home and signs a request to be discharged; or
(b) the resident leaves the home and informs the Administrator that he or she will not be returning to the home.

O. Reg. 79/10, s. 146 states:
(4) A licensee shall discharge a long-stay resident if,
(a) the resident is on a medical absence that exceeds 30 days.

During an interview, resident #001's family member indicated the resident was discharged from the home while resident #001 was in the hospital.

A review of resident #001's progress notes indicated they were transferred to the hospital on an identified date in December 2018, and was discharged from the home on an identified date in December 2018, seven days later. A progress note written by the previous DOC indicated the previous ED had received a call from a LHIN-CM who stated resident #001 was not coming back to the home anymore and had requested admission to another home. Another progress note indicated the hospital had phoned the DOC to inform them that resident #001 was stable and dischargeable at which time the DOC told the hospital that the resident's family had decided not to bring the resident back to the home.

During an interview, the home's previous staff #120, stated that someone from the LHIN had told them the family had indicated they did not want the resident to return, that the resident would not be returning and therefore they discharged resident #001 based on that. During an interview, staff #127 indicated the family had provided a request for discharge in writing. A review of this email indicated resident #001's substitute decision-maker indicated the resident was no longer a resident of the home and was requesting a copy of the resident's medical record. This email was dated on an identified date in December 2018, five days after the home had discharged resident #001.

During an interview, the LHIN-CM recalled speaking with the home and communicating that the family did not want resident #001 to return. According to them, the home took that to mean to discharge the resident which should not have occurred. In the manager's opinion, the home had discharged the resident too soon, did not wait for 30 days as is required and had not received a written request from the family to discharge the resident.

During an interview, staff #100 thought there had been some miscommunication between all parties but acknowledged that the home should have waited 30 days to discharge the resident. [s. 144.]

Issued on this 6th day of February, 2019

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

Original report signed by the inspector.