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
Jun 20, 2019	2019_644507_0020	017639-18, 027017-18, 027047-18, 029884-18, 001543-19, 009238-19	Critical Incident System

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

STELLA NG (507), JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 7, 10, 11, 12, 13, 14 and 17, 2019.

**The following intakes were completed in this Critical Incident System Inspection:
Log #027017-18 (CIS #2503-000030-18), log #027047-18 (CIS #2503-000029-18), log #029884-18 (CIS #2503-000035-18) and log #001543-19 (CIS #2503-000003-19) related to abuse allegation, and
log #017639-18 (CIS #2503-000019-18) and log #009238-19 (CIS #2503-000009-19) related to plan of care.**

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Managers (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Behavioural Support Ontario (BSO) Lead, Personal Support Workers (PSW), Physiotherapist (PT) and residents.

The inspectors conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

**The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

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

- **3 WN(s)**
- **1 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

A) A critical incident system (CIS) report was submitted to the Director on an identified date in regard to an improper treatment allegation.

Review of the CIS report and the progress notes indicated that resident #003's substitute decision-maker (SDM) reported to the home that resident #003 sustained injuries because of the staff member's improper care. The home completed the investigation one month later.

Further review of the CIS report did not identify an amendment that included the outcome of the investigation. This was acknowledged by staff #106 during an interview.

B) Another CIS report was submitted to the Director on an identified date in regard to an abuse allegation.

Review of the CIS report and the progress notes indicated that resident #007 reported to the home that an identified staff member abused them on an identified date. The home completed the investigation three days later.

Further review of the CIS report did not identify an amendment that included the outcome of the investigation. This was acknowledged by staff #106 during an interview. [s. 23. (2)]

C) A CIS report was submitted to the Director on an identified date regarding an allegation of abuse to a resident.

A review of the CIS report and the progress notes indicated that on an identified date, resident #008 stated that the staff hurt them during care. The allegation of abuse was investigated and it was not founded.

Further review of the CIS report did not identify an amendment that included the outcome of the home's investigation.

In an interview, staff #120 acknowledged that the CIS report was not amended to indicate the allegation was not founded. [s. 23. (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 the results of every investigation undertaken under clause (1) (a) and every action taken under clause (1) (b) is reported to the Director, 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:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #007 collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

On an identified date, a CIS report was submitted to the Director in regard to an abuse allegation. Resident #007 reported to the home that an identified staff abused them on an identified date. The police was notified of the allegation. The police completed the investigation eight days later, and informed the home that the allegation was unfounded.

A specific intervention was initiated when the police informed the home of the investigation outcome as indicated in resident #007's current care plan.

Record review of resident #007's progress notes three weeks prior indicated that resident #007 requested a specific intervention which was contradicted the intervention mentioned above. This was confirmed during interviews with staff #114, #115 and #117.

Record review of Daily Clinical Meeting Agenda two days after resident #007 made the request, the management team determined not to implement the intervention requested by the resident. This was confirmed during interviews with staff #106, #110, and #116.

On an identified date, approximately three weeks after resident #007 made the above mentioned request, the inspector observed the resident's requested intervention was in place.

In interviews, staff #110, #116 and #117 were not aware of the resident's requested intervention was in place despite the decision made during the above mentioned management team meeting. Staff #110 and #116 confirmed the team had failed to collaborate with each other in the development and implementation of resident #007's plan of care. [s. 6. (4) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff #119 complied with the written policy that promotes zero tolerance of abuse and neglect of residents.

A CIS report was submitted to the Director on an identified date in regard to an allegation of abuse to a resident.

Review of resident #008's progress notes indicated that on an identified date, the resident reported to their assigned staff member that the staff of a particular shift hurt them during care.

A review of the CIS report indicated that the allegation of abuse was reported to the Director the next day after the home became aware of the alleged abuse from the resident's SDM.

A review of the home's Zero Tolerance of Resident Abuse and Neglect policy #RC-02-02-02-A2, revised on April 2017, and interview with staff #106 indicated that the home's process is for front line staff to report the allegation of abuse to their direct supervisor, who would report to the ADOC, DOC, ED, and then they would report to the Director.

In an interview, staff #119 stated that they did not report the allegation of abuse to the home's management team or to the Director.

In an interview, staff #120 indicated that when the resident reported the allegation of abuse to the nursing staff, they should have reported to the senior management team on the same day. Staff #106 indicated staff #119 did not comply with the home's policy. [s. 20. (1)]

Issued on this 20th day of June, 2019

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

Original report signed by the inspector.