Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 22, 2020	2019_630589_0029	012155-19, 012260-19	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)

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): December 17, 18, 19, 20, and 23, 2019.

The following intakes were inspected:
Complaint log #012155-19 and Critical Incident System log #012260-19 related to an allegation of abuse.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director, Nurse Manager (NM), Registered Staff (RN/RPN), Personal Support Workers (PSW), and Substitute Decision Maker (SDM).

During the course of this inspection medical records and investigation records were reviewed, resident to staff interactions were observed, and any relevant policies and procedures were reviewed.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

During the course of this inspection, Non-Compliances were issued.
- **1 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. 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003's right to be afforded privacy in treatment was fully respected and promoted.

A critical incident system (CIS) report and a complaint from resident #003's substitute decision maker (SDM) were received by the Director which indicated that an identified mobile x-ray service technician had taken x-rays while resident #003 was in the washroom.

During a phone conversation with resident #003's family member they stated that resident #003 had called them to tell them that an x-ray technician had ignored their request to wait a minute while they exited the washroom, and that they opened the closed door, entered and stated it was okay to take these x-rays while the resident was in the washroom. Resident #003's family member also requested that the inspector not speak to the resident about this incident as it would bring back bad memories of that day. This request was honoured by the inspector.

During a conversation with staff #102, they stated that x-ray technicians from the mobile service typically notify staff that they are present in the long term care home (LTCH) to take an x-ray and was not sure why this did not happen on this day.

A review of the LTCH's investigation notes indicated the x-ray technician did not appear to have notified staff they were present in the LTCH to take an x-ray of resident #003 that morning.

Staff #102 acknowledged resident #003's right to be afforded privacy in treatment had not been fully respect and promoted. [s. 3. (1) 8.]

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 every resident's right to be afforded privacy in treatment is fully respected and promoted, to be implemented voluntarily.

Issued on this 23rd day of January, 2020

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

Original report signed by the inspector.