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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 18, 2020	2019_804600_0027 (A1)	012271-19, 017113-19, 017553-19, 018513-19, 021427-19, 022470-19, 023991-19	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

Amended by GORDANA KRSTEVSKA (600) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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This report was amended for extension of the compliance due date, change of the title of one of the staff member and change of a number of staff interviewed.

Issued on this 18th day of February, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by GORDANA KRSTEVSKA (600) - (A1)

Amended 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): December 17, 18, 19, 20, 23, 27, 30, & 31, 2019, January 2, & 3, 2020. December 24, 2019, off-site.

The following intakes were completed in this Critical Incident System report inspection:

#012271-19, #017113-19, 017553-19, 021427-19, 023991-19, related abuse and neglect,

#018513-19, related to personal services,

#022470-19, related safe and secure home.

Please note a non-compliance identified in Complaint inspection #2019_833763_0003, for intake #017901-19 related to Pain Management, has been issued in this report.

During this inspection an inspector initiated inspection was conducted for unsafe positioning while eating.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Acting Executive Director, (A-ED), Acting Director of Care (ADOC), Recreational Manager (RM), Nurse Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Food Service Manager (FSM), Dietary Aid (DA), Personal Support Workers (PSW), housekeeping staff, Substitute Decision Maker (SDM) and residents.

During the course of the inspection, the inspectors conducted observations of the home including resident home areas, resident and staff interactions, the

provision of residents' care, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

- **7 WN(s)**
- **4 VPC(s)**
- **1 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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist resident #043 with eating, including safe positioning.

This non-compliance was identified during the inspection in the home and was inspector initiated.

On an identified date while passing by a resident's room Inspector #589 heard resident #043 coughing. The resident had a tray in front of them and was trying to have breakfast. It was observed that the resident was not properly positioned. When asked, the resident stated they wished to be positioned higher in the bed so they can better reach their food. It was also observed that the remote control of the bed and the call bell were not within the resident's reach. There was no Personal Support Worker (PSW) or registered staff around.

Registered Practical Nurse (RPN) #104, who was attending the dining room, was asked to see resident #043 in their room. When asked what the practice in the home is for serving residents in their rooms, the RPN said that the resident who needs a tray in their room for meals, should be served after all other residents are assisted with feeding in the dining room and when staff are available to check up on them, in and out, for supervision. The RPN was asked, if the resident was positioned appropriately; the RPN stated that the resident was not positioned properly; they should be seated upright, the head of the bed to be positioned to 90 degrees.

In an interview, PSW #106, who was assigned to resident #043, stated that they brought the tray and left it close to the resident, but they did not position the

resident for breakfast as the resident was starting to exhibit a responsive behaviour so they left the food tray within the resident's reach on their bedside table and left. When asked if leaving the resident in an inappropriate position was a risk to the resident, the PSW responded yes, and tried to explain that the resident had a responsive behaviour and they were not able to reposition the resident. The PSW also said that the residents receiving a tray in their room were to be served after the residents in the dining room finished their breakfast, but they would not have time after breakfast in the dining room to provide trays in residents' rooms.

A review of resident #043's plan of care indicated they required assistance for feeding.

In an interview, the A-ED acknowledged that resident #043 was not properly positioned when the PSW #106 brought a tray in their room for breakfast. [s. 73. (1) 10.]

2. As a result of non-compliance identified with resident #043, the scope was expanded to include resident #044.

On an identified date, the inspectors observed a resident in an identified room, who also had a food tray in their room for an identified meal. The resident was observed to be not properly positioned with a food tray on their bedside table within reach. The resident was reaching for food trying to self-feed. When approached, the resident told Inspector #589 that they wanted to be lifted higher up in the bed. The RPN was notified.

A review of resident #044's plan of care indicated that the resident required supervision at meals and stipulated that the resident be positioned at 90 degrees during meals and snacks.

Interview with RPN #104 indicated that the resident should be properly positioned when they have a meal in the dining room or in bed. The RPN stated that resident #044 was not properly positioned for their meal.

In an interview, PSW #106 indicated that the residents were to be positioned properly when having their meal and to be supervised. The PSW said they had many residents on tray service that morning so they just left the tray on the bedside table in front of resident #044. Further they stated they wanted to come

back and assist with positioning, but were busy with other residents that needed assistance.

In an interview, the A-ED stated the staff had training about proper positioning of residents and are expected to position and supervise the resident prior to assisting with the activity. The A-ED acknowledged that resident #044 was not properly positioned at the identified meal time. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Ministry of Long Term care (MLTC) on an identified date, regarding an incident of suspected abuse.

A review of the CIS report indicated that on the specified date, PSW #109 notified RPN #108 that resident #007 had a new area of skin impairment. As per RPN's progress note documentation, the PSW informed the RPN that the skin impairment was noticed while assisting the resident with an identified activity of daily living. The RPN mentioned that when resident #007 was assessed, the resident alleged an abuse by staff. A review of the home's investigation showed PSW #109 was reprimanded for not providing care to resident #007 as indicated in the resident's plan of care.

A review of the resident’s MDS assessment and plan of care prior the incident, indicated that resident #007 required assistance from two staff for three identified activities of daily living.

In an interview, PSW #109 indicated that they were familiar with resident #007 and had provided care to the resident sometimes. The PSW stated that on the identified date, they provided care to the resident to help the other staff. Further the PSW stated that when they were assisting in an identified activity, they noticed a new area of impaired skin integrity. The PSW notified the RPN, who came and assessed the resident. In the interview, the PSW stated that on the identified date, they had provided the identified assistance alone, and had not been aware the resident's plan of care was revised to include assistance from two staff for the identified activity.

also stated that they were aware of resident #007 need for identified assistance, unless the resident experienced a responsive behaviour. On this morning the resident was collaborative so the PSW provided the care. However, the PSW also stated that they had not reviewed resident #007’s plan of care prior to providing care although they had it on the electronic documentation, and they were not aware when and if the resident’s plan of care was revised.

In an interview, the A-ED stated the staff is expected to review the plan of care

prior to the provision of care to the resident and be aware if there are any changes in the plan. The A-ED also stated, PSW #109 did not review the plan of care on the identified date, and did not provide care as the plan of care indicated. [s. 6. (7)]

2. The licensee has failed to ensure that when resident #010's care needs changed, the plan of care was reviewed and revised.

A CIS report was submitted to the MLTC detailing an incident on a specified date, in an identified common area, where resident #010 was observed to exhibit a responsive behaviour towards resident #011. Resident #011 reacted to the behaviour. Staff separated the two residents and implemented interventions to protect resident #011, including placing resident #010 in a small common area, away from resident #011.

Resident #010's written plan of care on an identified date, indicated they were to be placed in the small common area to protect resident #011 from any further behaviours from resident #010.

Resident #011's written plan of care on the specified date, included a safety plan for resident #011 to prevent any further behaviours from resident #010, which included direction to staff to ensure resident #010 was not in proximity to resident #011 at all times.

On the specified date, inspector observed resident #010 and #011 during an identified activity. Inspector observed resident #010 in the common area, seated facing away from resident #011 at a table. Neither residents appeared to be in distress. When asked, PSW #112 explained resident #010 was not sitting at their assigned place in different common area because of a recently exhibited another responsive behaviour towards another resident who was also in the small common area, and that staff were ensuring resident #011 continued to be protected from #010 by close staff monitoring.

During an interview, RPN #132 confirmed resident #010 was no longer seated in the small common area because of a responsive behaviour with another resident in the small common area. RPN #132 explained they made this change on an identified date, however they forgot to update resident #010's and resident #011's plan of care to notify staff of the change. RPN #132 confirmed it was the home's expectation that, when care needs change for a resident, these changes are

immediately updated in their plan of care.

A-ED #102 confirmed it was the home's expectation that, when care needs change for a resident, these are immediately updated in their plan of care. A-ED #102 confirmed that when resident #010's seating arrangement needs changed, this information should have been updated immediately in resident #010's and resident #011's plan of care.

The licensee has failed to ensure that when resident #010's care needs changed, the plan of care was reviewed and revised. [s. 6. (11) (b)]

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 care set out in the plan of care is provided to the resident as specified in the plan,
to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan or policy, the plan or policy was complied with.

In accordance with LTCHA, s. 87 (1), and in reference to O. Reg. 79/10, s. 230 (4) (1) (vii) the licensee was required to have an emergency plan in place dealing with situations involving a missing resident.

Specifically, the staff did not comply with the licensee's "Code Yellow-Missing Resident" policy #EP-06-01-01 (dated January 2019), which indicated that, "as soon as a resident is missing, a Code Yellow procedure, which is defined as an immediate and systematic search of the home and surrounding area, will be followed". The policy indicated that a "Code Yellow emergency is progressive, meaning the longer a resident is missing, the higher the level of risk to the resident and the home". In addition, the policy noted that "residents are considered missing when they are not in a location where staff can find them." Procedures of the policy indicated that if the resident has not been located within 10 minutes of the incident manager being notified, regardless of the completeness of the current search for the resident, the incident manager must have immediately announced or delegated an employee to announce a Code Yellow page over the home's announcement system, then followed with additional procedures such as notifying the police of the missing resident.

A CIS report was submitted to the MLTC detailing an incident involving resident #005 who was found missing for identified time on an identified date.

A review of resident #005's record indicated resident #005 was admitted to the

home on an identified date. Resident #005 was able to independently sign themselves out for Leave of Absence (LOA), for personal activities. Resident #005 was also known to spend time on another floor of the facility.

Record review indicated that, on an identified date, resident #005 signed themselves out of the facility at an identified time without informing staff of where they were going. Staff noted resident #005 did not return for meal service. Staff checked eight hours and 11 hours later , however noted resident #005 was not in the facility and had not signed back in. The nurse manager called resident #005's family to inquire into resident #005's whereabouts. Staff continued to check the main lobby for the resident at identified period of times. A-ED #102 was informed of resident #005 being missing 19 hours after the resident signed out, at which point A-ED #102 delegated the office manager to page a Code Yellow emergency, and A-ED #102 delegated staff to follow Code Yellow procedures such as notifying the police of resident #005 not being in the home. Resident #005 was located with assistance from the police and co-residents and later returned to the facility.

Staff interviews indicated that it was typical for resident #005 to leave the facility and not inform the staff, and to not inform the staff of their whereabouts. Staff found it difficult to be aware of resident #005's whereabouts at all times often visit another floor of the facility or be on LOA. Staff also noted resident #005 could exhibit responsive behaviour if staff asked them of their whereabouts.

RPN #113 who worked the on the identified date, noted resident #005 would often return to the home from LOA on their shift and was not sure why a Code Yellow emergency was not called during their shift.

During an interview, RPN #105 noted that it was staff expectation to consider a resident missing after doing initial rounds and determining the resident was not present. RPN #105 noted that, since staff could not determine resident #005's whereabouts on their initial search, a Code Yellow emergency should have been paged, and management should have been notified. RPN #105 was not sure why staff on duty at the time of the incident did not page a Code Yellow emergency, however noted the manager on duty for the night was aware of the situation.

During an interview, A-ED #102 noted that it was not typical for resident #005 to be out of the facility for the length of time indicated, which is why staff called resident #005's family to inquire into their whereabouts. A-ED #102 was not sure

why a Code Yellow emergency page was not initiated until A-ED #102 started their shift. A-ED #102 indicated that they expected the staff, such as the nursing manager, to have initiated Code Yellow procedures, or expected them to call upper management for further instructions if they weren't sure if a Code Yellow emergency plan needed to be initiated.

The licensee has failed to ensure that staff complied with the licensee's "Code Yellow-Missing Resident" policy which indicated that, if the resident has not been located within 10 minutes of the incident manager being notified, they must have immediately announced or delegated an employee to announce a Code Yellow emergency page over the home's announcement system and continued on with additional Code Yellow procedures, such as notifying the police of the incident. [s. 8. (1)]

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 where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, the plan is complied with, to be implemented voluntarily.

WN #4: 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 their written policy to promote zero tolerance of abuse, was complied with related to resident #008.

A CIS report was submitted to the Director on an identified date, which indicated that resident #008 was approached by an identified PSW who asked to borrow money from the resident on an identified date. The CIS report also indicated that later that day they told PSW #101 about what had happened.

During a conversation with resident #008, they were able to recall the incident where a PSW had asked to borrow money from them. Resident #008 stated the PSW followed them back to their room after meal service and whispered in their ear to borrow money. Resident #008 did not have any money on them to lend to the PSW. Resident #008 also stated that they were not aware that a staff member asking to borrow money was inappropriate as the PSW was not a stranger to them. They would see the PSW mostly everyday and that they served them their meals in the dining room. Resident #008 further stated that if they had any money on them at the time, they may have lent the money to this PSW.

A review of resident #008's health record indicated their daily decision making skills were not impaired. The health record also indicated that resident #008 was able to communicate clearly with the staff.

During an interview, PSW #101 stated that the resident had told them that a PSW had asked to borrow money earlier the same day but did not give them any because they did not have any money with them. PSW #101 also stated that they told resident #008 this needed to be reported but the resident asked them not to say anything to anyone. PSW #101 stated that they initially did not report this incident, but it was on their mind, knowing this was wrong, so after one and half days they reported the incident to RPN #103.

During an interview, RPN #103 verified that PSW #101 reported the above-mentioned incident to them and in turn they reported it to the RN nurse manager on shift.

A review of the LTCH's policy titled: Zero Tolerance of Resident Abuse and Neglect Program, # RC-02-01-01, indicates on page six the definition of financial abuse as follows:
Any misappropriation or misuse of a resident's money or property, with one of the

examples cited as, the borrowing of money from a resident.

The identified PSW was not interviewed as they no longer worked at the LTCH.

During an interview, A-ED acknowledged that the identified PSW had received education on the prevention of abuse three times over the last one year and a half, and verified that the LTCH's written policy to promotes zero tolerance of abuse, had not been complied with by the identified PSW. [s. 20. (1)]

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 their written policy to promote zero tolerance of abuse, is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A CIS was submitted to the MLTC on an identified date, regarding an incident that

caused an injury to resident #009 for which the resident was taken to the hospital and which resulted in a significant change in the resident health status. On a specified date, the resident was assessed with an injury and was sent to hospital for further assessment.

A review of the hospital discharge summary resident health record titled "Health Records, Scarborough Hospital Discharge summary" from an identified date, indicated a discharge diagnosis for resident #009 included a complex change in resident #009's condition.

On an identified date, the resident was identified to have a change in an identified body part and the plan was the resident to be assessed every week until the change healed and treatment to be provided as per order to manage the discomfort.

A review of the resident’s progress notes for the period of 11 days, prior to hoapitalization, indicated that an identified assessment was done weekly, treatment was provided, and it was effective. However, on a specified date, in the morning, resident #009 started complaining of discomfort of the identified body part. A scheduled treatment was provided, and an identified assessment was initiated, but the identified body part was not assessed for discomfort, only the part that was causing discomfort from before. Resident complained again in the evening of discomfort of the identified body part, and the scheduled treatment was provided with good effect. No indication that the identified assessment was done. On the identified date, at 0400 and 1900 hours it was documented that the resident complained of discomfort, now with extension of the identified body part. Again, the scheduled treatment was provided, the identified assessment initiated, but the identified body part was not assessed. It was the next day, when RPN #114 went to assess resident #009 after they complained of discomfort to PSW #115. On assessment, the RPN identified signs of a change in resident #009's condition and the resident was sent for further assessment.

In an interview, RPN #114 stated that the practice in the home is to assess the resident for discomfort on admission, quarterly, every time when they complain of discomfort, and if the treatment they received was not effective. The RPN also said that when the resident initially complained of discomfort of the identified body part, although the resident was on specified treatment, the registered staff should have assessed the resident's identified body part for discomfort.

In an interview, nurse manager (NM) #116 stated that the practice in the home was the resident to be assessed for discomfort on admission, every quarter, when the resident is on an identified treatment but not effective or new discomfort is identified. The NM acknowledged that resident #009 was not assessed for discomfort when they complained of the identified body part that was not reported before. The staff was to use the tool from PCC, assess resident when they initially complained, and document their finding. [s. 52. (2)]

2. A complaint regarding pain management was submitted to the MLTC on an identified date. A review of resident #002's record indicated resident #002 was admitted to the home on with multiple diagnoses and chronic discomfort. Resident #002's had changed health condition and they required a specified assistance for all their activities. Documentation, interviews and observations indicated frequent exhibiting an identified responsive behaviour of both care and assistance due to the change and chronic discomfort.

Record review and interviews with direct care and nursing staff indicated resident #002 suffered chronic and ongoing daily discomfort secondary to their change in condition, resisting identified treatments to manage the discomfort. Resident #002 had orders for an identified treatment to be applied three times a day to identified body parts to relieve some discomfort, however as per documentation, staff and resident, they refused most treatments. Several non-pharmacological interventions to manage and distract the resident from their discomfort were included in their plan of care.

Interview with direct care staff and nursing staff indicated current treatment to manage discomfort for resident #002 were not always effective and often refused.

A review of resident's records indicated several progress notes reporting resident was experiencing ongoing discomfort.

During an interview, RPN #105 stated that current care plan interventions in place to manage resident #002's discomfort were not always effective. For residents with chronic discomfort, it was the home's expectation that an identified assessment tool would need to be completed on a weekly basis to monitor the discomfort. RPN #105 confirmed that they completed the assessment on an identified date, and indicated resident #002 did not have any discomfort at the time of assessment. RPN #105 confirmed that after this assessment was completed, the resident verbalized and showed signs of discomfort, indicating a

change in the resident's status after the assessment that month. RPN #105 was not sure why resident #002 did not have any more assessments completed until the end of the year.

During an interview, A-ED #102 confirmed that when a resident experienced new discomfort, or suffered from chronic discomfort, it was an expectation that staff would complete a clinically appropriate assessment instrument to determine sources of discomfort and interventions to manage, in the form of a PCC assessment with an identified title. A-ED #102 acknowledged that, since resident #002 suffered from chronic discomfort and that current interventions to manage discomfort for resident #002 were not always effective, staff were expected to include a weekly comprehensive assessment as part of their plan of care. A-ED #102 confirmed there were not enough assessments completed for resident #002 from the identified period.

The licensee has failed to ensure that when resident #002's discomfort was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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 when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006 was protected from financial abuse.

For the purposes of the definition of abuse in subsection 2 (1) of the Act, financial abuse means any misappropriation or misuse of a resident's money or property.

A CIS report was submitted to the Director on an identified date. The CIS report indicated that resident #006's personal items had gone missing from their room. The long-term care home (LTCH) notified resident #006's family member and conducted an internal search for the missing items.

A review of the home's investigation notes indicated that resident #006 had been interviewed, and indicated that resident #006 had left their two items on their bed when they left the room. When they returned, they were both gone.

A further review of the CIS report indicated that on an identified date, resident #006's family member had contacted the LTCH's previous ED to notify them that they had pictures taken on the one of the missing items that captured the person who was in possession of it. These photos were sent to the previous ED who recognized the person as a staff member of the LTCH. During this inspection, the pictures were viewed by the inspector and the current ED on their computer. The pictures indicated the person who had possession of the item and the date and time the pictures had been taken, which was the same date when the resident's items went missing.

A further review of the home's internal investigation notes indicated that during an interview, the identified staff member denied having possession of the item. The LTCH's investigation notes also indicated that the previous ED had contacted outside resources for more information regarding the item. The notes indicated that the representative stated that the time and date on a picture indicates when it was taken and that the picture is then uploaded to the cloud automatically.

During an interview, A-ED #102 verified that resident #006 had not been protected from financial abuse. [s. 19. (1)]

2. The licensee has failed to ensure that resident #011 was protected from abuse by resident #010.

A CIS report was submitted detailing an incident on an identified date, in the main common area, where resident #010 was observed exhibiting an identified behaviour towards resident #011. Resident #011 reacted to that behaviour. Staff separated the two residents and implemented interventions to protect resident #011 from future behaviour, including seating resident #010 in the small common area, away from resident #011. The CIS report indicated that a similar incident occurred on another identified date where resident #010 exhibited an identified behaviour towards resident #011 and was moved to another seating in the common area.

Record review indicated resident #011 was admitted to the home with identified diagnoses and a CPS score indicating impaired cognition.

Record review of resident #010's chart indicated resident #010 had history of an identified responsive behaviour towards staff throughout their admission.

Review of resident #011 and #010's records indicated that after the identified date, incident (to be referred to as "the second incident"), staff completed several tasks to manage the incident, as well as implemented interventions to prevent future incidents, such as seating resident #010 in the small common area, away from resident #011. This information was added to both resident care plans and documented in the residents' charts after the second incident.

Record review of resident #010 and #011's records revealed that on the specified date, the incident (to be referred to as "the first incident"), was not documented and was not communicated to home staff.

RPN #114 confirmed that they worked as charge nurse during the incident on the specified date, when staff resident #010 exhibited an identified responsive behaviour toward resident #011. RPN #114 noted they did not remember if they documented about this first incident, but felt it was not necessary at the time because they thought resident #010 only attempted the behaviour. They only

found out that resident #010 did indeed exhibited the identified behaviour towards resident #011 during the first incident after the home investigated both incidents. RPN #114 confirmed that it was staff expectation for staff to update oncoming shifts of attempted or actual identified behaviour so that staff are aware and can prevent the incidents from happening, however RPN #114 noted they did not remember if they communicated this information to the oncoming shift for the first incident.

During an interview, RPN #132 confirmed they witnessed the second incident on the identified date. RPN #132 explained they only found out about the first incident, when direct care staff told them about it after the second incident already occurred. RPN #132 checked the residents' charts after the second incident occurred but found no documentation of the first incident. RPN #132 noted that they would have ensured interventions to manage the behaviours were implemented to avoid the second incident if they were aware of the first incident. RPN #132 explained that when incidents like this happened it was expected that staff in charge of the unit would document the incident and notify oncoming staff about the incident via a shift report.

ED #102 noted that when care needs of a resident change, it is the expectation of staff to communicate the change to incoming staff at shift report. They also noted that it is staff expectation to report any identified incidents immediately so that interventions to manage them can be implemented. ED #102 acknowledged that on the specified date, the charge nurse was expected to document the incident and report it to the nurse manager on that shift, whether or not the incident was attempted or actual, so that appropriate action to manage and prevent any future incidents would be taken.

The licensee has failed to ensure that resident #011 was protected from abuse by resident #010.

This is additional evidence to compliance order (CO) #001 under s. 19 (1) inspection #2019_530726_0006, issued on September 10, 2019, with a Compliance Due date (CDD) of December 6, 2019. [s. 19. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the name of the staff member who were present at the incident involving resident #006.

A CIS report was submitted to the Director on an identified date, by the former ED. The CIS report indicated that resident #006's personal items went missing from their room on a specified date. On an identified date, the former ED received an email from resident #006's family member indicating they had evidence indicating the items were in another person's possession. These photos were sent to the former ED, who recognized it to be a current staff member.

A review of the CIS report indicated all fields of the report had been completed except for the name of the staff member involved in the incident.

During an interview, the A-ED #102, stated they had not been a part of this internal investigation and was not aware that the staff member involved in the incident had not been identified in the CIS report as required by legislative requirements. [s. 104. (1) 2.]

Issued on this 18th day of February, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by GORDANA KRSTEVSKA (600) - (A1)
Inspection No. / No de l'inspection :	2019_804600_0027 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012271-19, 017113-19, 017553-19, 018513-19, 021427-19, 022470-19, 023991-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 18, 2020(A1)
Licensee / Titulaire de permis :	CVH (No. 1) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	Craiglee Nursing Home 102 Craiglee Drive, SCARBOROUGH, ON, M1N-2M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rebecca Macaalay

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To CVH (No. 1) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

The licensee must be compliant with O.Reg 79/10, r. 73. (1)

Specifically, the licensee must:
1. Ensure that proper techniques are used to assist residents #043 and #044 and any other resident who requires assistance with eating, including safe positioning of residents,
2. Re-educate all direct care staff on proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
3. Maintain attendance records of all staff who participated in the education, including the topic and dates of the education,
4. All staff must ensure that residents are supervised when they receive tray service,
5. Develop, implement and maintain an auditing process to ensure that staff are using proper techniques and positioning when feeding residents, including those eating in their room and the residents are supervised,
6. Maintain a written record of audits conducted in the home. The written record must include the date of the audit including which shift, the residents' name and room number, staff member(s) audited, the name of the person completing the audit, the outcome of the audit, and the follow up action.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that proper techniques were used to assist resident #043 with eating, including safe positioning.

This non-compliance was identified during the inspection in the home and was inspector initiated.

On an identified date while passing by a resident's room Inspector #589 heard resident #043 coughing. The resident had a tray in front of them and was trying to have breakfast. It was observed that the resident was not properly positioned. When asked, the resident stated they wished to be positioned higher in the bed so they can better reach their food. It was also observed that the remote control of the bed and the call bell were not within the resident's reach. There was no Personal Support Worker (PSW) or registered staff around.

Registered Practical Nurse (RPN) #104, who was attending the dining room, was

asked to see resident #043 in their room. When asked what the practice in the home is for serving residents in their rooms, the RPN said that the resident who needs a tray in their room for meals, should be served after all other residents are assisted with feeding in the dining room and when staff are available to check up on them, in and out, for supervision. The RPN was asked, if the resident was positioned appropriately; the RPN stated that the resident was not positioned properly; they should be seated upright, the head of the bed to be positioned to 90 degrees.

In an interview, PSW #106, who was assigned to resident #043, stated that they brought the tray and left it close to the resident, but they did not position the resident for breakfast as the resident was starting to exhibit a responsive behaviour so they left the food tray within the resident's reach on their bedside table and left. When asked if leaving the resident in an inappropriate position was a risk to the resident, the PSW responded yes, and tried to explain that the resident had a responsive behaviour and they were not able to reposition the resident. The PSW also said that the residents receiving a tray in their room were to be served after the residents in the dining room finished their breakfast, but they would not have time after breakfast in the dining room to provide trays in residents' rooms.

A review of resident #043's plan of care indicated they required assistance for feeding.

In an interview, the A-ED acknowledged that resident #043 was not properly positioned when the PSW #106 brought a tray in their room for breakfast. [s. 73. (1) 10.] (600)

2. As a result of non-compliance identified with resident #043, the scope was expanded to include resident #044.

On an identified date, the inspectors observed a resident in an identified room, who also had a food tray in their room for an identified meal. The resident was observed to be not properly positioned with a food tray on their bedside table within reach. The resident was reaching for food trying to self-feed. When approached, the resident told Inspector #589 that they wanted to be lifted higher up in the bed. The RPN was notified.

A review of resident #044's plan of care indicated that the resident required supervision at meals and stipulated that the resident be positioned at 90 degrees during meals and snacks.

Interview with RPN #104 indicated that the resident should be properly positioned when they have a meal in the dining room or in bed. The RPN stated that resident #044 was not properly positioned for their meal.

In an interview, PSW #106 indicated that the residents were to be positioned properly when having their meal and to be supervised. The PSW said they had many residents on tray service that morning so they just left the tray on the bedside table in front of resident #044. Further they stated they wanted to come back and assist with positioning, but were busy with other residents that needed assistance.

In an interview, the A-ED stated the staff had training about proper positioning of residents and are expected to position and supervise the resident prior to assisting with the activity. The A-ED acknowledged that resident #044 was not properly positioned at the identified meal time. [s. 73. (1) 10.]

The severity of this issue was a level 2 as there was minimal risk to the residents. The scope was level 2 as the non-compliance affected two of three observed residents. Compliance history was a level 3 as the home's compliance history included the following non-compliance with the same subsection that included:
- Written Notification (WN) and Voluntary Plan of Corrections (VPC) issued September 10, 2019, (2019_530726_0006). (600)

Apr 30, 2020(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of February, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by GORDANA KRSTEVSKA (600) - (A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Service Area Office / Bureau régional de services : Toronto Service Area Office