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 30, 2020	2019_804600_0026	019136-19	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

GORDANA KRSTEVSKA (600)

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, 23, 27, 30, & 31, 2019, January 2, & 3, 2020. December 24, 2019, off-site.

The following intakes were completed in this Complaint Inspection: #019136-19, regarding to personal care.

During the course of the inspection, the inspector(s) spoke with the former Executive Director (ED), the Acting-Executive Director (A-ED), Acting Director of Care (A-DOC), 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 inspector conducted observations of the home including resident home areas, the provision of residents' care, resident and staff interactions, 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
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the Ministry of Long -Term Care (MLTC) on an identified date, regarding resident #001. Substitute Decision maker (SDM) was concerned about resident #001's missed follow up appointment.

In an interview, resident #001's SDM indicated that the resident had an identified health problem and had been visiting an specialist prior the admission to the home. After the admission, the home and the SDM had established a process for the resident to be able to attend their follow up appointments regularly. The SDM stated that even though the team had a plan in place to make sure the resident attended the appointments, the resident still had missed an appointment that, according to the specialist's letter, may have affected the outcome of the resident's treatment.

Review of the resident's clinical record indicated that due to the resident's chronic condition, the resident was referred for an assessment to the outside specialist whenever the resident's condition worsened and follow up appointment would be scheduled. The process was set so that after the initial assessment, the specialist's office would send a date for the follow up appointment and the registered staff would communicate to the SDM and clarify the date, transportation and escort, confirming with the specialist's office the date. On an identified date, the evening staff received a faxed prescription from the dermatologist and endorsed to the upcoming staff to follow up and clarify the order. The night staff documented that they received a fax order from the specialist identifying two orders: to clarify the treatment and to book a wheel trans and escort for another specialty appointment on specified date, referred by the previous specialist. The day staff on another identified date documented that the resident was to have a follow up appointment with the previous specialist in two weeks after the visit. On the identified date, the unit clerk documented that the resident had an appointment with a second specialist, referred by the first specialist, indicating that wheel trans had been booked and SDM to be notified. The SDM escorted the resident to the second specialist appointment on the identified date. About ten days later, the evening staff received a letter from the first specialist, indicating concern as the resident did not show up on the follow up appointment on a specified date.

A record review indicated no follow up was scheduled regarding the resident's follow up appointment with the first specialist. However, during the review, a fax letter from the first specialist's office, from an identified date, indicated that the resident's next follow up appointment was to be scheduled in two weeks.

In an interview, the DOC/unit clerk indicated that there is a process in the home regarding scheduling follow up appointments, booking wheel trans and escort. Once the registered staff receive a fax or letter from the outside specialty, they notify the SDM and clarify if the family prefer to take the resident to the appointment, or they prefer the home to schedule wheel trans and escort. Once that is straightened out, the registered staff endorse the information to the DOC/unit clerk, and they follow up. Once they complete, they copy the information about the appointment time, wheel trans pick up and drop off time, escort name and company and send a copy to the registered staff on the floor and one copy, including the original fax letter from the outside specialty, in the binder provided to keep track of all the appointments. They also document in the resident's progress notes.

A review of the binder mentioned above indicated that the previous DOC/unit clerk that actually had booked this appointment, started collecting these records and filed them in a binder after the identified date. However, the calendar that the DOC/unit clerk was keeping as a reference, showed the scheduled appointment for the second specialist only, none for the first.

The DOC/unit clerk stated that they were not working at the time when these appointments were to be booked, but they stated that the calendar indicated that the follow up appointment on the identified date was not booked.

An interview with Registered Practical Nurse (RPN) #108, who documented that the resident had a follow up appointment, indicated that they were not aware that the dermatologist had faxed a letter for two separate appointments, one referral to a second specialty on an identified date and other for follow up appointment with the first specialty in two weeks time.

The licensee has failed to ensure the plan of care was provided when resident #001's follow up appointment was not scheduled.

2. A complaint was submitted to the MLTC on an identified date, regarding resident #001 who was discharged from the home. The SDM was concerned when the home sent resident #001 in a wheel trans on a trip into the community alone, with no food and no treatment.

An interview with SDM and review of the resident's progress notes indicated that often

the SDM would notify the home when they wanted to take the resident to the trip, so the home would prepare packed food and the resident's treatment. On an identified date the SDM notified the home that on a specified date they would be in the home at an identified time to pick up the resident to take them for a trip, and they asked that a packed meal and the treatment to be ready for them.

A review of the resident's progress notes from an identified date, indicated that the Acting Executive Director (A-ED), a Director of Care (DOC) at that time, sent resident #001 in wheel trans to the community around an identified time as the SDM did not show up and the wheel trans would not wait. The resident was not given the treatment and no packed lunch. Fifteen minutes later, the SDM came to the home upset that the resident was sent alone, with no food and no treatment. The DOC offered to go after the resident and would bring the food and the treatment medication.

In the interview, the SDM expressed concern why the resident was sent alone by the wheel trans despite notification to the home that they would come to the home and join the resident on the trip.

In an interview, PSW #110, indicated that very often the resident was prepared to go into the community on an identified day. The staff would get the resident ready after breakfast, the kitchen staff would pack the food and the nurse would hand the treatment to the SDM prior to leaving the home. The PSW was not aware what happened on the identified date as they were still in the dining room.

In an interview, the A-ED indicated that on an identified date, they were in the home doing rounds and they noticed the wheel trans was waiting for resident #001. Further the A-ED said that they asked the driver to wait for the SDM, but the driver told them they have to go as they had other residents to pick up. Thinking that the SDM might wait for the resident at the community, the A-ED stated, they sent the resident by the wheel trans. Further the A-ED indicated that sometimes the SDM had let the resident go alone to some appointments and they would meet them there, the AED thought the SDM might be at the destination so that is why they sent the resident. However, the A-ED acknowledged that the plan that the SDM explained the day before was the resident would be joined by the SDM. [s. 6. (7)]

3. A complaint was submitted to the MLTC on an identified date, regarding resident #001 who was discharged from the home in 2019. The SDM expressed concern when they

identified the resident's picture in the home's news paper.

A record review of the resident's health record indicated that on a specified date, SDM had signed a "Recreation Consent Form" indicating that they consent for a photo to be taken for admission picture only. However, in an identified month in 2018, resident #001's picture appeared on page four of the home's newspaper during a holiday breakfast photo shoot.

An interview with the Recreation Manager (RM) indicated that the process in the home is when a new resident is admitted in the home, the resident or the SDM would be asked to sign a photo consent choosing choices provided on the form. The manager stated that they were aware of the SDM's concern and they ensured extra measures were taken from then on, that no resident would have their picture taken, without an updated consent from the family. The manager also stated they were sorry for what happened, the act was not intentional as the volunteer was not focusing on the resident, but they accidentally showed on the page.

In an interview, the A-ED acknowledged that the staff did not follow the resident's plan of care when they published resident #001's picture for the home newspaper. [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 care set out in 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. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #001, #007 and #040 received fingernail care, including the cutting of fingernails.

A complaint was submitted to the MLTC on an identified date regarding resident #001 who was discharged from the home in 2019. The SDM was concerned about resident #001's fingernail care.

In an interview, the SDM indicated many times they found resident #001's fingernails had not been cut or trimmed and cleaned. On a specified date, the SDM had taken a picture and submitted to the MLTC with the complaint. The picture revealed resident's nails were not trimmed and cleaned, and they had black dirt underneath.

A review of the resident's plan of care under focus of Impaired Skin Integrity indicated that among other interventions the staff was to ensure the resident's fingernails were cut and trimmed at all the times and the goal was to prevent infection. A review of the PSW daily documentation record for an identified month of 2019, indicated that no fingernail care was provided to resident #001.

An interview with PSW #110 indicated that the resident's fingernail care was to be done every time before and after meals and cut and trim at each bath.

PSWs assigned to resident #001 at the time of the complaint were not available.

An observation conducted on an identified date, on one of the floors discovered that resident #007's fingernails were not cut or trimmed and were not cleaned. Further observation also discovered that resident #040 had long nails and the resident was coming forward to ask the nurse to have their fingernails cut, as they were long and they were not able to cut their fingernails by themselves anymore.

An interview with RPN #111 indicated that the staff was to clean the resident's fingernails daily and cut and trim on bath days. The RPN agreed that resident #007's nails were not cleaned and resident #040's fingernails were long.

In an interview with the A-ED, they acknowledged that resident #007 and #040 did not receive fingernail care at the time of the inspection, and resident #001 was not provided fingernail care at the time of the complaint. [s. 35. (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 each resident of the home receives fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home had been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

A complaint was submitted to the MLTC on an identified date, regarding a broken personal item that resident #001 kept at the bedside table.

In an interview, the SDM indicated that the resident had a personal item that was kept at the bedside table at the time of the religious holidays and it meant a lot to the resident. The SDM could not recall the date, but they recalled that one day when they came in, they found the item at the bedside table, but it was broken. None of the staff they talked to, knew what or how it happened so the SDM took a picture of the broken item and reported it to the Social Worker.

Review of the home's Complaint record indicated that there was a Complaint Investigation Form completed for a complaint received on the identified date, regarding a broken personal item, as well as two other complaints. There was no indication that an investigation or action taken had been conducted. The form had not been signed by the manager, as indicated on the bottom of the form, although the findings indicated that the complaint was founded.

In an interview, the Social Worker (SW) indicated that they recall the SDM of resident #001 coming forward and reporting the broken item. They further stated that they reported that on the morning manager’s meeting to the former Executive Director (ED) and the DOC (A-ED). However, the SW stated that they did not do the investigation about the complaint, as they had endorsed the complaint to the former ED and former DOC because it was “their area”.

In an interview, the A-ED, former DOC, stated that they heard about the complaint but did not conduct any investigation about this complaint and they were not sure why their name was on the complaint log as a member of the staff leading the investigation.

In an interview, the former ED of the home indicated that they recalled the complaint and they talked to the SDM apologizing for the broken item. The former ED further stated that they did not conduct any investigation to find out what happened and did not respond back to the SDM within the 10 business days of receiving the complaint. [s. 101. (1) 1.]

Issued on this 12th day of February, 2020

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

Original report signed by the inspector.