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
Feb 28, 2020	2020_630589_0005	002548-20	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

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 19, 20, 24, 25 & 26, 2020.

The following inspection was conducted:
-Log #002548-20 related to plan of care concerns.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director (I-ED), Interim Director of Care (I-DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietitian (RD), Personal Support Workers (PSW), 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, resident to resident interactions, the provision of resident care, reviewed clinical health records, internal investigation notes and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that a plan of care was developed for resident #006 related to their new health diagnosis.

A complaint was submitted to the Director related to concerns regarding resident #006's care needs, which resulted in the resident being transferred to hospital and subsequently being diagnosed with a new health condition.

A review of resident #006's clinical health record indicated that they had been admitted to the long term care home (LTCH with existing underlying health conditions and that a new health condition had been diagnosed during a hospital transfer. A review of resident #006's care plan did not indicate this new health condition had been identified and a review of progress notes did not indicate an interdisciplinary discussion had been conducted regarding the management of this health condition.

During an interview, staff #109 indicated that they would monitor for specific identified signs and symptoms and they further indicated that this would be integrated into resident #006's care plan.

During an interview, staff #101 stated that they would have expected staff to have a plan of care in place for resident #006's new health condition. [s. 26. (3) 9.]

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 a plan of care is developed with respect to the resident's disease diagnosis, to be implemented voluntarily.

WN #2: 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:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a response was made to resident #006's substitute decision maker (SDM) after their complaint made to the licensee concerning the monitoring and assessment of resident #006, that indicated what the licensee had done to resolve the complaint, and/or that the licensee believes the complaint to be unfounded and the reasons for the belief.

A complaint was submitted to the Director related to concerns about resident #006's care needs. The complainant stated that the long-term care home's (LTCH) staff had not been aware of resident #006's identified symptom until they had brought it to their attention.

A review of the LTCH complaints binder indicated a complaint investigation form had been initiated and then completed the next day when resident #006 transferred to hospital. A further review indicated under the interview record details, that resident #006's family member had not been satisfied with the LTCH's interventions and therefore requested a transfer to hospital for a second opinion.

During an interview, staff #101 acknowledged initiating the complaint investigation form but since resident #006 was transferred to hospital, the investigation was closed. Staff #101 further acknowledged that after resident #006 was re-admitted to the LTCH, they did not contact their family member to discuss the outcome of their investigation related to what actions had been taken to resolve the complaint, and the reason why the internal investigation was closed. [s. 101. (1) 3.]

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 for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident is dealt with as follows: that a response is made to the person who made the complaint, indicating what the licensee has done to resolve the complaint and/or what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

Issued on this 3rd day of March, 2020

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

Original report signed by the inspector.