Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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
Mar 29, 2021	2021_833763_0005	015858-20, 019114-20, 019867-20, 024380-20, 004159-21	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

IANA MOLOGUINA (763)

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): March 2, 9, 10, 11, 12, 15, 16, 17 and 18, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

- Log #024380-20, CIS #2503-000039-20 was related to falls.
- Log #019867-20, CIS #2503-000032-20 was related to alleged abuse.
- Log #019114-20, CIS #2503-000031-20 was related to alleged neglect.
- Log #004159-21, CIS #2503-000002-21 was related to a missing resident.
- Log #015858-20 was a follow-up intake for Compliance Order #001 from inspection #2020_808535_0009 with a compliance due date of September 30, 2020.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Services Worker (SSW), environmental services staff, administration staff, dietary manager and residents.

During the course of this inspection, the inspector reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provision.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_808535_0009	763

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 for a resident was provided to them as specified in the plan.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report indicating that the resident fell from their assistive device onto the floor. The fall resulted in significant injury and a transfer to hospital. The report indicated that the home implemented a new falls management intervention to be used to manage their falls risk, but it was not used during the time of the fall. Resident records also indicated that this intervention should have been in place at the time of the fall.

The PSW who assisted the resident just prior to the fall occurring indicated that they did not use the indicated intervention because they were not aware that the resident needed it. The home’s staff confirmed that the resident should have used the intervention at the time of the fall as indicated in their plan of care.

Sources: resident records (risk management assessments, progress notes, care plan), CIS #2503-000039-20, staff interviews (PSW #116, RPN #107, and ADOC #111). [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 in ensuring that the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: 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 Head Injury Routine (HIR) monitoring required under the home's falls policy was completed for a resident's fall.

O. Reg 79/10, s. 48 (1) required the licensee to ensure a falls prevention and management program was developed and implemented in the home to reduce the incidence of falls and the risk of injury. Specifically, staff did not comply with the home’s policy "Falls Prevention and Management Program" that indicated HIR monitoring needed to be completed when a resident hit or may have hit their head after a fall. This included monitoring several vital signs every four hours for the first four hours after the fall, and then every eight hours for 72 hours.

The resident was at risk of falls and experienced occasional falls in 2020, including an unwitnessed fall which required HIR monitoring. HIR monitoring documentation for that fall was incomplete for one of the shifts that required monitoring of the resident every eight hours for 72 hours. Staff confirmed HIR monitoring should have been completed on that shift but believed it was forgotten.

Sources: resident clinical records (care plan, progress notes, assessments, risk management assessments), CIS #2503-000039-20, "Falls Prevention and Management Program" policy #RC-15-01-01 (last updated December 2019), staff interviews (RPN #107, RPN #106). [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that their skin and wound care program policy was complied with when staff did not document a skin impairment order on the Treatment Administration Record (TAR) for a resident.

O. Reg 79/10, s. 48 (1) required the licensee to ensure a skin and wound care program was developed and implemented in the home to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. Specifically, staff did not comply with the home’s policy "Skin and Wound Program: Wound Care Management" that directed the nurse/wound care lead to ensure treatment regimens for skin breakdown were documented by recording the treatment regimen on the TAR.

The MLTC received a CIS report alleging neglect of the resident after nursing staff discovered that the resident was missing treatment orders for a skin impairment since their admission. The report indicated that treatment orders were not implemented until approximately three weeks after the admission when staff first discovered the omission.

The resident was admitted to the home with several ongoing skin impairments. Treatment and monitoring orders were not implemented at the time of admission for one of the impairments. Staff confirmed the impairment required routine monitoring and treatments to be ordered on the TAR since their admission as per the home’s policy and procedures. Staff and record reviews confirmed that treatment and monitoring of the impairment continued throughout admission despite the TAR orders being missed.

Sources: resident clinical records (care plan, progress notes, assessments, TAR), CIS #2503-000031-20, “Skin and Wound Program: Wound Care Management” policy # RC-23-01-02 (last updated August 2019), staff interviews (RPN #107, staff #115). [s. 8. (1) (b)]

WN #3: 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 a resident was protected from physical abuse by PSW #123 during care.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone that causes physical injury or pain.

The MLTC received a CIS report detailing an incident where the resident sustained significant injury. The resident indicated that PSW #123 used physical force during care which resulted in the injury and requested that PSW #123 did not provide any care to them in the future.

The home conducted an investigation of the incident and confirmed that physical abuse occurred during the incident as PSW #123 used physical force during the provision of care which caused physical injury to the resident. Interviews with staff involved confirmed the same.

The above is further evidence to support the compliance order issued on July 30, 2020, during complaint inspection #2020_808535_0009 with a compliance due date of September 30, 2020.

Sources: resident observations, resident records (progress notes, hospital records), CIS #2503-000032-20, staff interviews (PSW #116, PSW #119, ED #100). [s. 19. (1)]

Issued on this 20th day of April, 2021

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

Original report signed by the inspector.