Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: September 5, 2023	
Inspection Number: 2023-1079-0005	
Inspection Type: Critical Incident	
Licensee: CVH (No. 1) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)	
Long Term Care Home and City: Craiglee Nursing Home, Scarborough	
Lead Inspector Reji Sivamangalam (739633)	**Inspector Digital Signature** Reji K Sivamangalam Digitally signed by Reji K Sivamangalam Date: 2023.09.19 12:08:55 -04'00'
Additional Inspector(s) Patricia McFadgen (000756)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 21-24, 2023
The inspection occurred offsite on the following date(s): August 25, 28, and 30, 2023

The following intake(s) were inspected:

- Intake: #00085979 [Critical Incident System (CIS) #2503-000016-23] related to fall prevention and management
- Intake: #00088005 (CIS #2503-000018-23) related to improper care of a resident.

The Following intake (s) were completed:

- Intake: #00008354 (CIS #2503-000018-22), #00009011 (CIS #2503-000020-22), #00010793 (CIS #2503-000022-22) and #00019375 (CIS #2503-000007-23) were related to fall prevention and management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when a resident was transferred post-fall.

Rationale and Summary

A resident had a fall and the staff member inappropriately positioned and transferred the resident after the fall.

The home's Falls Prevention and Management program policy directed staff to only position and transfer the resident after a fall after completing a specific intervention.

The staff members verified that unsafe transferring techniques were used that did not align with the home's policy.

There was a risk to the resident to sustain injuries when unsafe transferring techniques were used.

Sources: Resident's clinical records, home's Fall Prevention and Management Program policy and interviews with staff members.

[739633]

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

The licensee has failed to ensure that the staff implemented interventions to prevent a resident's responsive behaviours.

In accordance with O. Reg. 246/22 s 11 (1) (b), the licensee was required to ensure that there are policies developed for responsive behaviours and must be complied with. Specifically, the staff did not comply with the home's responsive behaviour policy, as it required staff to re-approach residents when they exhibited responsive behaviours.

Rationale and Summary

While receiving care, the resident was not demonstrated responsive behaviours and resulted in a negative outcome for the resident.

According to the staff members, they should have stopped providing care when the resident exhibited responsive behaviours, and re-approached when the resident became cooperative instead of continuing the care.

There was a risk of harm to the resident when the staff did not stop and re-approach when the resident exhibited responsive behaviours.

Sources: CIS report, home's Responsive Behaviours policy, resident's clinical records, interviews with staff members.

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WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that assessments were documented for a resident's responsive behaviours.

Rationale and Summary

Specifically, the Behavioural Support Ontario-Dementia Observation System (BSO-DOS) Data Collection Sheet documentation and assessment were not completed.

The BSO-DOS Data Collection Sheet was used for documenting the resident's behaviours to identify the behavioural triggers. It was a paper-based tool and documented by direct care staff at a frequency of every half hour. When the BSO-DOS observation is complete, the Behavioral Support Lead (BSO Lead) completes the BSO assessment by reviewing the observations and identifying potential behavioural triggers.

A DOS monitoring was initiated for a resident from a specified date and continued for five days. A review of the BSO-DOS documentation showed missing information for a specified period, and after the observation period, the BSO assessment was not completed.

The staff members acknowledged that the DOS monitoring was not completed as required, and the observation should have been analyzed after their completion with an assessment.

Failure to document BSO-DOS and complete the analysis assessment could result in not identifying the behavioural triggers for the resident.

Sources: Resident's clinical records, interviews with staff members.

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