Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 7, 2012 | 2012_049143_0053 | 0-000413-12/~~00722-~~ 000721-12 | Critical Incident System |

**Licensee/Titulaire de permis**

CRAIGLEE NURSING HOME LIMITED
c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1

**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**

PAUL MILLER (143)

**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): December 5-6th, 2012**

**Two Critical Incident Inspections were completed as part of this report. Log # O -000413-12(CIS#2503-000005-12)and Log # O-000722-12(CIS#2503-000010-12)**

**During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Nursing, the Assistant Director of Nursing, Registered Practical Nurses, Personal Support Workers and residents.**

**During the course of the inspection, the inspector(s) Reviewed health care records inclusive of physician orders and assessments, Geriatric Outreach Team Assessments, progress notes and nursing assessments, reviewed abuse policies and procedures and observed resident care and services.**

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

**Hospitalization and Death**

**Prevention of Abuse, Neglect and Retaliation**

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

**s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

**Findings/Faits saillants :**

The following findings are related to Log #O-000722-12:
1. On a specified date and time Resident #1 was physically abused by Resident #2. Resident #2 pulled resident #1 from his/her wheelchair and pushed him/her to the floor. Resident #1 was observed lying on his/her side and complained of pain. Resident #1 received analgesic with some effect to treat discomfort. Police and Power of Attorney's were notified and resident #2 was transferred to hospital. A Critical Incident Report was submitted to the Ministry of Health and Long Term Care on a specified date.
On December 6, 2012 the Administrator and the Director of Nursing were interviewed and reporting requirements were reviewed and discussed. It is noted that neither of these Senior Managers were in their current positions at the time of the incident. In discussion with the Administrator and Director of Nursing it was confirmed that the Director (Ministry of Health and Long Term Care- Compliance Branch) was not notified of the results of the abuse investigation.
The licensee has failed to comply with LTCHA 2007 section 23.(2) by not reporting the results of the abuse investigation. [s. 23. (2)]

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**

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**Findings/Faits saillants :**

1. On a specified date and time Resident #1 was physically abused by Resident #2. Resident #2 pulled resident #1 from his/her wheelchair and pushed him/her to the floor. Resident number #1 was observed lying on their side and complained of pain. Resident #1 received analgesic with some effect to treat their discomfort. Police and Power of Attorney's were notified and resident #2 was transferred to hospital. A Critical Incident Report was submitted to the Ministry of Health and Long Term Care two days later.
The Licensee has failed to comply with LTCHA 2007 section 24.(2) by not immediately reporting physical abuse of a resident that resulted in harm or risk of harm to a resident. [s. 24. (1)]

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**Issued on this 20th day of December, 2012**

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