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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 5, 2013	2013_179103_0057	000370,000427, 000646	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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

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

DARLENE MURPHY (103)

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): October 28, 31, Nov 1, 4, 2013

Five critical incidents were reviewed during this inspection.

During the course of the inspection, the inspector(s) spoke with a Registered Practical Nurse, a Registered Nurse, the Social Worker, the Assistant Director of Care, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) completed a walk through of the resident units, made resident observations, reviewed resident health care records and reviewed the home's policy on abuse and neglect.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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, s. 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, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 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, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, s. 24 (1) whereby incidents of abuse of a resident that resulted in harm or risk of harm to a resident were not immediately reported to the Director.

On an identified date, an altercation occurred between Residents #2 and #4 and resulted in resident injury. The incident was not reported to the Director until a critical incident was submitted the following day.

On another identified date, an altercation occurred between Residents #1 and #3 and resulted in resident injury. The incident was not reported to the Director until a critical incident was submitted the following day.

During a resident health care record review, an altercation was noted to have occurred between Residents #2 and #5 on an identified date which resulted in resident injury. This incident was not reported to the Director.

On an identified date, an altercation occurred between Residents #2 and #4 and resulted in a resident injury. The incident was not reported to the Director until a critical incident was submitted four days later.

In a discussion with the Director of Care (DOC), the unreported incident was believed to be the result of a system error as the DOC had all of the related documentation except for the critical incident. In all of the above incidents, the home had appropriately notified the police, physician and Power of Attorneys in accordance with the legislated requirements. [s. 24. (1)]

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 all incidents of abuse of a resident by anyone that results in harm or a risk of harm to the resident are immediately reported to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 104 (1) 5 whereby reports made to the Director in writing with respect to the alleged, suspected or witnessed incidents of abuse of a resident did not include whether an inspector had been contacted.

Five critical incidents submitted by the home were reviewed. All of the incidents reported resident to resident abuse. The reports did not include whether an inspector had been contacted and, if so, the date of the contact and the name of the inspector. [s. 104. (1) 5.]

Issued on this 5th day of November, 2013

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