Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
August 11, 12, 13, 2010	2010_104_2503_11Aug15242	Critical Incident: O-000892

Licensee/Titulaire
Craiglee Nursing Home Ltd
c/o Deloitte & Touche - 181 Bay Street
Brookfield Place, Suite 1400
Toronto, ON, M5J 2V1
Fax: 416-601-6690

Long-Term Care Home/Foyer de soins de longue durée
Craiglee Nursing Home
102 Craiglee Drive, Scarborough, ON, M1N 2M7
Fax: 416-264 2190

Name of Inspector(s)/Nom de l'inspecteur(s)
Judy Macaulay, #104

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection related to 2503-000058-10.

During the course of the inspection, the inspector spoke with the Administrator, the Director of Care, registered nursing and PSW staff.

During the course of the inspection, the inspector reviewed the resident's record.

The following Inspection Protocol was used during this inspection:
Hospitalization and Death

☐ There are no findings of Non-Compliance as a result of this inspection.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with: O. Reg. 79/10, s. 24(1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home.

Findings:

1. The 24-hour admission care plan for an identified resident was developed and dated five days after admission.

Inspector ID #:	104

WN #2: The Licensee has failed to comply with: O.Reg. 79/10, 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,

(b) is complied with.

Findings:

1. The home is required to have policies developed for the medication management system. [O.Reg. 79/10, s. 114 (2)]
2. There was no physician order written to hold a specified medication when an identified resident's condition changed.
3. There was no documentation on the Medication Administration Record to reflect the physician's directions to hold the specified medication when this resident's condition changed.
4. The progress notes stated that the physician was notified of the resident's condition and the physician's response to the staff was to hold the specified medication.
5. The Home's policy was not complied with related to recording and processing of physician's orders: *04-03-03, Health Care Records Manual Documentation Procedures, Frequency of Recording, reviewed June 2004.*
6. According to documentation on the Medication Administration Record, the specified medication was held on that day by the registered staff related to his change in condition.

Inspector ID #:	104

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: Nov 4/10