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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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
July 28- 29, 2010	2010_103_2503_28Jul124546	Critical Incident O-000491 (CIS# 2503-000056-10)

Licensee/Titulaire
Craiglee Nursing Home Limited, c/o Deloitte & Touche Inc., 181 Bay St., Brookfield Place, Suite 1400, Toronto, Ontario M5J 2V1 Fax# 1-416-601-6690

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

Name of Inspector(s)/Nom de l'inspecteur(s)
Darlene Murphy (#103)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to the death of a resident.

During the course of the inspection, the inspector spoke with 1 Registered Practical Nurse, 1 Registered Dietician and 2 Personal Support Workers.

During the course of the inspection, the inspector reviewed the resident health care record.

The following Inspection Protocol was used during this inspection:

Hospitalization and Death Inspection Protocol.

☐ 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:

1 WN
1 VPC

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.

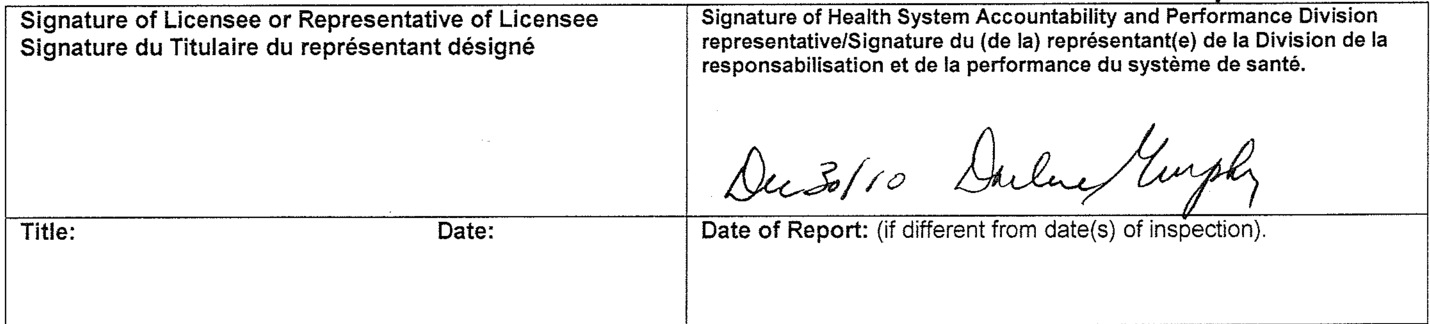
WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 6 (1)
Every licensee of a long term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the residents:
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident

Findings:

1. The resident was assessed by the Registered Dietician (RD) on June 21, 2010; On the Resident Assessment Protocol (RAP), the RD documented the resident had "chewing difficulties" which "places him/her at risk for choking and aspiration". The RD's suggestion was to change his/her diet from minced to pureed with thin fluids.
2. Doctor's orders dated July 10, 2010 for the resident indicate a new order for a diabetic diet, pureed in texture.
3. At the time of this inspection (July 28/29, 2010), the resident's written plan of care had been last updated on June 10, 2010 and indicated the resident receives a Regular diet that is a minced texture.
4. Prior to the new order for a pureed diet, the progress notes indicate on at least four occasions the resident received foods which were not consistent with the order for a minced diet:
    - July 4, 2010, the resident was given a muffin by staff;
    - July 6, 2010 and July 8, 2010 the resident was given cookies by staff
    - July 9, 2010, the resident was given a sandwich by staff
5. Two Personal support workers (PSW) who stated they were familiar with the care needs of the resident were interviewed. One PSW stated the resident was on a minced diet; the second PSW stated the resident was on a regular textured diet.
6. A Registered Practical Nurse (RPN) was interviewed and indicated the resident had foods left on his bedside table which were not the appropriate texture for this resident.
7. The food was not removed from the bedside table until the RPN directed the PSW to do so the next day at about 0830.

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 staff receive clear directions on the residents ordered texture of foods, to be implemented voluntarily.



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. Dec 30/10 Darlene Murphy
Title:	Date:	Date of Report: (if different from date(s) of inspection).