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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

☐ 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
September 23 & 27, 2010	2010_111_2503_20Oct144856	CIS (Log # 0-000983)

Licensee/Titulaire
Craiglee Nursing Home Limited,
c/o Deloitte & Touche Inc.,
181 Bay Street East,
Brookfield Plaza, 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)
Lynda Brown (ID# 111)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a CIS inspection related to a resident who sustained a serious injury from a fall.

During the course of the inspection, the inspector spoke with the Administrator, the Director of Care and a PSW on the first floor.

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

The following Inspection Protocols were during this inspection:
Medication, Minimizing restraints

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

4 WN

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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.131 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Findings:
1. An identified resident was not administered a drug in accordance with the directions for use as specified by the prescriber.

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.31 (3). If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that, (d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations

Findings:
1. **An identified resident being restrained was not reassessed when it was determined that the use of the restraint was ineffective.**

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WN #3: The Licensee has failed to comply with O.Reg. 79/10, s.26 (3).
A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with the respect to the residents:
10. Health conditions, including allergies, pain, risk of falls and other special needs.
19. Safety risks.

Findings:
1. **An identified resident at risk for falls did not have a plan of care in place to address the safety risks and the risk for falls and the resident sustained serious injuries as a result.**

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WN #4: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the need and preferences of that resident.
Findings: **An identified resident who sustained serious injury from a fall did not receive care based on the current assessed needs of that resident.**
Inspector ID #: 111

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: Dec 8/10.	**Date of Report:** (if different from date(s) of inspection). Nov. 23, 2010