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

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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 13, 19, 21, 22, Apr 13, 23, 24, 25, 26, 27, 2012	2012_048175_0004	Critical Incident

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

BRENDA THOMPSON (175)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), One Registered Nurse (RN), One Personal Support Worker (PSW)

During the course of the inspection, the inspector(s) reviewed Critical Incident Report, health care record of resident #1, Responsive Behaviour Policy & Procedure #09-05-01, observed resident #1 in the Dining Room and other resident home areas on the nursing unit

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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.) 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. 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. 6. Plan of care

Specifically failed to comply with the following subsections:

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 resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Critical Incident Report indicates resident #1 repeatedly hit resident #3.

2.Resident #1 Care Plan was reviewed and indicated nursing interventions were to identify what has triggered verbal and physically aggressive behaviours toward other residents and to establish interventions to minimize the frequency of exposing the resident to the trigger. If exposure to the trigger can't be minimized, collaborate with members of the interdisciplinary team to determine if the trigger can be altered in any way to minimize the response.

3.Review of resident #1's nursing progress notes indicated 9 separate incidents of resident #1 exhibiting physical and verbally threatening behaviours toward other residents, over a 3 month period. Documented potential triggers prior to incidents, included a resident trying to go into resident #1's room, residents repeatedly banging into resident #1's wheelchair, being very close to personal space, or repeated targeting of particular residents.

4.Geriatric Mental Health Assessment of resident #1,recommended medications as ordered when required and/or send to hospital if violent toward others.

5.RN was interviewed and indicated the trigger is when someone touches resident #1's wheelchair or blocks the way. There is a particular resident who the resident #1 targets. We always make sure that they don't get close to each other, especially in the dining room. We separate resident #1 from other residents by putting him in the bedroom for a few minutes. There is a new referral completed for follow up with Ontario Shores. Psychiatrist has told staff to call police if resident #1 behaviours are bad.

6.PSW was interviewed and indicated a trigger for resident #1 is if someone bangs into the wheelchair. Resident#1 will hit out.

The licensee failed to ensure resident #1's plan of care was reviewed and revised to include specific reported triggers related to violent physical and verbal behaviours and written strategies and interventions to prevent, minimize or respond to the responsive behaviours.In addition, the licensee did not ensure resident #1's care plan provides clear directions to staff and others who provide direct care to the residents.(Ref s.6.(10)(b); s. 6(1)(c)).

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 residents exhibiting responsive behaviours are re-assessed and their plans of care are reviewed and revised to include specific identified triggers related to responsive behaviours and written strategies and interventions to prevent, minimize or respond to them.Clear directions must be provided to staff and all others who provide direct care to the resident., to be implemented voluntarily.

Issued on this 2nd day of May, 2012

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