Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 3, 2020	2020_630589_0004	022167-19, 022276-19, 024126-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

JOANNE ZAHUR (589)

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): February 19, 20, 24, 25, & 26, and off-site; February 28, 2020.

The following inspections were conducted:
-Log #024126-19 related to transferring and positioning,
-Log #022167-19 related to responsive behaviours, and
-Log #0222176-19 related to alleged verbal abuse.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director (I-ED), Interim Director of Care (I-DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector conducted observations of the home including resident home areas, resident and staff interactions, resident to resident interactions, the provision of resident care, reviewed clinical health records, internal investigation notes and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

The licensee has failed to ensure that the provision of care set out in the plan of care was documented for resident #004.

A critical incident system (CIS) report was submitted to the Director. The CIS report indicated that an incident occurred where resident #004 exhibited a responsive behaviour towards resident #005 resulting in an injury.

During an interview, staff #102 stated that a specific observation tool was to be completed for an identified number of days for resident #004 after the above-mentioned incident.

A review of the observation tool for this time period indicated documentation was not completed on four identified days during specific time frames.

Staff #100 and staff #102 acknowledged that the licensee had failed to ensure that the provision of care set out in the plan of care was documented for resident #004. [s. 6. (9)]

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 that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that resident #005 was protected from physical abuse by resident #004.

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, physical abuse means, the use of physical force by a resident that causes injury to another resident; (mauvais traitement d’ordre physique).

A critical incident system (CIS) report was submitted to the Director. The CIS report indicated that an incident occurred where resident #004 exhibited a responsive behaviour towards resident #005 resulting in an injury.

During a conversation with resident #005, they had no recall about the incident.

During an interview, staff #105 stated that they had observed resident #004 exhibit a responsive behaviour toward resident #005 in the hallway, which resulted in resident #005 sustaining an injury.

During an interview, staff #109 stated they assessed resident #005's injury and noted an area of altered skin integrity. Staff #109 further stated that resident #005 complained of discomfort. At the time of this inspection, the area of altered skin had healed.

A review resident of #004's health record indicated that they have a history of responsive behaviours towards other residents and that they are under the care of the LTCH's internal behavioural support program, and external consultants.

The licensee has failed to ensure that resident #005 was protected from physical abuse by resident #004.

This is additional evidence to compliance order (CO) #001 under s. 19 (1) inspection #2019_530726_0006, issued on September 10, 2019, with a compliance due date (CDD) of December 6, 2019, which was compiled at the time of this inspection. [s. 19. (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 every licensee of a long-term care home shall protect residents from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure staff used safe positioning techniques when assisting resident #003.

A CIS report submitted to the Director indicated that resident #003 presented with altered skin integrity to an identified body area. The CIS report also indicated that upon a head to toe assessment by staff #104, resident #003 was not experiencing any discomfort.

A review of resident #003's health record indicated they required total assistance with transferring with two staff present using an identified mechanical lift. A further review of the health record indicated that resident #003 was not on any specific medical therapy that could cause altered skin integrity. A review of the LTCHs internal investigation notes and a further review of the CIS report indicated that during transfers, resident #003 could exhibit responsive behaviours.

During an interview, staff #100 stated that as a result of their internal investigation, the transferring aid was changed to a new transferring aid which provided more comfort and proper positioning to resident #003 during transfers.

As the previous transferring aid was no longer being used with resident #003, a demonstration by staff #116 indicated how the transferring aid straps would cause pressure against a resident's body if the resident exhibited the responsive behaviours.

Staff #100 acknowledged that the LTCH's internal investigation concluded that improper positioning during the transfer had resulted in the areas of altered skin integrity that resident #003 sustained. [s. 36.]

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 staff use safe positioning techniques when assisting residents, to be implemented voluntarily.

Issued on this 4th day of March, 2020

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

Original report signed by the inspector.