Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: October 15, 2024
Inspection Number: 2024-1079-0002
Inspection Type: Complaint Critical Incident Follow up
Licensee: CVH (No. 1) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Craiglee Nursing Home, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 17-19, 23-27, and October 1-2, 2024

The inspection occurred offsite on the following date(s): September 20, 23, 2024

The following intake(s) were inspected in the Complaint Inspection:
Intake: #00115370 - related to concerns regarding purchasing an ambulatory device
Intake: #00123967 - related to housekeeping, supplies, and maintenance services
Intake: #00124913 - related to allegations of neglect and improper care

The following intake(s) were inspected in the Follow-Up Inspection:
Intake: #00114449 ; Intake: #00114450 - related to a previously issued Compliance Order under Inspection #2024-1079-0001

The following intake(s) were inspected in the Critical Incident System (CIS) Inspection:

Intake: #00124565 - 2503-000027-24 - related to Infection Prevention and Control (IPAC)
Intake: #00121226 - 2503-000025-24 - related to a fall of resident resulting in injury
Intake: #00115994 - 2503-000020-24; Intake: #00120063 - 2503-000023-24 - related to an injury of unknown cause of a resident
Intake: #00122771 - 2503-000026-24 - related to alleged physical and emotional abuse of a resident

The following intake(s) were completed in the CIS Inspection:
Intake: #00120934 - 2503-000024-24 - related to a fall of resident resulting in injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #002 from Inspection #2024-1079-0001 related to O. Reg. 246/22, s. 102 (2) (b)
Order #001 from Inspection #2024-1079-0001 related to FLTCA, 2021, s. 184 (3)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to be Treated with Respect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect and in a way that fully recognized their inherent dignity, was fully respected.

Rationale and Summary

A resident was being assisted for care by multiple staff. The resident was resistive while staff tried to encourage them. The staff were not able to get the resident to comply with care; staff undressed the resident despite the resident resisting, and then staff approached with an assistive device where the resident was seated and taken into a room for care.

Video surveillance of the incident showed that the resident was in a common area at the time of the incident before being seated in the assistive device and taken into the room.

Registered staff confirmed that they witnessed the resident being undressed in the common area before the resident was seated in the assistive device and taken into the room.

Failure to treat the resident with courtesy and respect by affording privacy resulted in an infringement on their right to be treated in a way that fully recognizes their inherent dignity.

Sources: Home's investigation notes, video surveillance of the incident, interviews with the home's staff

WRITTEN NOTIFICATION: Safe Transfers and Zero Lift Policy

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure their safe transfer policy was complied with when staff were assisting a resident with a transfer.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee is required to ensure that staff use safe transferring techniques when assisting residents. Specifically, staff did not comply with the policy "Home's Safe Lifting with Care Program" at the time of the incident.

Rationale and Summary

A resident was being assisted for care by staff when they fell and sustained an

injury. Staff obtained the help of another staff, and together they attempted to manually lift the resident from the floor to the chair.

The home's Safe Lifting with Care Program policy indicated that the home integrated a Zero Lift program, which eliminates all manual resident lifting for safety purposes.

Staff acknowledged that manually lifting the resident placed the resident at risk of harm.

Failure to use proper transferring techniques increased the risk of further injury.

Sources: Home's Safe Lifting with Care Program Policy, Home's investigation notes of the incident, A resident's care plan, interview with the home's staff

WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure their post-fall procedures were complied with when a resident had fallen.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee is required to ensure that

their required policies are complied with. Specifically, staff did not comply with the home's policy and procedure, "Falls Prevention and Management Program," at the time of the incident.

Rationale and Summary

While being assisted for care by staff, a resident fell and sustained an injury. The staff did not immediately report it to the nurse. Two staff members attempted to manually lift and transfer the resident before they were assessed by a nurse.

The home's falls prevention and management policy stated care staff are to report any incidents of a resident found on the floor or resident fall immediately to the registered staff, and that prior to a resident being transferred post-fall, the resident must be assessed by a registered staff.

Failure to immediately report to the registered staff when the resident had fallen and ensuring the resident was assessed by a registered staff post-fall before being transferred placed the resident at risk to cause further injury.

Sources: Home's investigation notes of the incident, home's Falls Prevention and Management Program policy, interview with the home's staff

COMPLIANCE ORDER CO #001 Plan of care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Provide education to two staff on the provision of mobility/transfer assistance in accordance with a resident's plan of care.

2) Provide education to a staff member on the provision of continence care in accordance with a resident's plan of care and the home's policies and procedures.

3) Provide education to three staff on a resident's behavioural interventions.

4) Provide training and education to two staff on a resident's falls prevention interventions and education on the home's policy specifically related to the importance of reviewing and implementing falls prevention strategies.

5) Maintain a record of education from steps 1-4, including the content of the education, the date, the staff members who received the education, and the staff member(s) who provided the education.

6) Conduct random audits, at a minimum twice weekly, for a period of three weeks on the care provision for residents who require specific assistance with repositioning by the two staff in accordance with a resident's plan of care.

7) Conduct random audits, at a minimum twice weekly, for a period of three weeks on the care provision for residents who require specific assistance with continence care by the staff in accordance with a resident's plan of care.

8) Conduct audits, at a minimum twice weekly on for specific resident care, for a period of two weeks to ensure the resident's behavioural interventions are being implemented.

9) Conduct random audits, at a minimum twice weekly, for a period of two weeks to ensure a resident's fall prevention interventions are being implemented.

10) Maintain a record of the audits from steps 6-9, including the date, who conducted the audit, the name of the staff being audited, the name of the resident(s) who are being provided with care, and the results of each audit and actions taken in response to the audit findings.

Grounds

i) The licensee has failed to ensure that a resident's responsive behaviour interventions were provided to the resident as specified in the plan of care.

Rationale and Summary

A resident's care plan identified that there were interventions related to responsive behaviours.

On a specified date, staff did not implement several care planned interventions for the resident.

Failure to implement the resident's care planned interventions increased the risk of the resident not receiving their scheduled care.

Sources: Observations on specified dates; a resident's care plan and progress notes; interviews with the home's staff

ii) The licensee has failed to ensure that fall prevention interventions for a resident were provided to the resident as specified in the plan.

Rationale and Summary

A resident's care plan identified them as a high risk for falls with a specified behaviour. The interventions implemented to prevent falls included ensuring that the bedside was clutter-free with no tripping hazards and that a specific intervention was in place.

While the resident was asleep in bed, it was noted that there was garbage on the floor around their bed. Also, the specified intervention was not in place, which a staff member confirmed was missing.

Failure to have the falls interventions in placed the resident at risk for falls.

Sources: Observations, the resident's care plan, the home's investigation notes of the fall incident, interview with the home's staff.

iii) The licensee has failed to ensure that staff provided care to a resident as specified in their plan of care.

Rationale and Summary

A resident's care plan indicated they required two-person assistance for specific care. A staff member provided care to the resident by themselves. On a different date, another staff member provided care to the resident by themselves. Later that shift, the staff discovered a skin alteration on the resident, and subsequent assessments revealed the resident sustained an injury.

The Executive Director (ED) indicated that staff were expected to follow the resident's care plan and should have provided the care with two staff.

Failure to ensure that staff provided care as specified in the plan of care increased the risk of injury to the resident.

Sources: Interview with the home's staff and management; review of a resident's clinical records; home's investigation notes.

This order must be complied with by November 8, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.