



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 12, 2013	2013_229213_0033	L-000649-13	Critical Incident System

Licensee/Titulaire de permis

CRAIGWIEL GARDENS

221 MAIN STREET, R. R. #1, AILSA CRAIG, ON, N0M-1A0

Long-Term Care Home/Foyer de soins de longue durée

CRAIGHOLME

221 MAIN STREET, R. R. #1, AILSA CRAIG, ON, N0M-1A0

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

RHONDA KUKOLY (213)

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): September 6 & 10, 2013

**During the course of the inspection, the inspector(s) spoke with the Director of
Care, the Administrator, 2 Residents, 3 Registered Nurses and 3 Personal
Support Workers**

**During the course of the inspection, the inspector(s) made observations;
reviewed health records, policies and other relevant documentation**

The following Inspection Protocols were used during this inspection:



Critical Incident Response

Medication

Pain

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records



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Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The home failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with as evidenced by:
 1. The home's pain management policy indicates that a pain assessment will be completed quarterly and following a change in a resident's condition affecting pain.
 2. The Director of Care confirmed that it is an expectation that a pain assessment is completed quarterly and following a change in condition affecting a resident's pain.
 3. A resident had not had a pain assessment completed in the past 18 months including after an incident which affected this resident's pain. [s. 8. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents



Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

- 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
- 2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).**
- 3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
- 4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
- 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

- 3. Actions taken in response to the incident, including,**
 - i. what care was given or action taken as a result of the incident, and by whom,**
 - ii. whether a physician or registered nurse in the extended class was contacted,**
 - iii. what other authorities were contacted about the incident, if any,**
 - iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and**
 - v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 107 (4).**
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Findings/Faits saillants :



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1. The home failed to inform the Director no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance as evidenced by:

1. A controlled substance was found missing on August 16, 2013.
2. The critical incident report regarding the missing controlled substance was submitted on August 20, 2013.
3. The Director of Care confirmed that she is aware that the missing controlled substance is to be reported to the Director no later than one business day after the occurrence and that she had not done so. [s. 107. (3)]

2. The home failed to ensure the written report included actions taken in response to the incident, including:

- i. what care was given or action taken as a result of the incident, and by whom,
- v. the outcome or current status of the individual or individuals who were involved in the incident

as evidenced by:

1. The report did not include the names of staff members involved in or investigated regarding the missing controlled substance.
2. The Director of Care confirmed that she did not speak to any staff members who had been on shift during or prior to the controlled substance being discovered as missing and that she had not investigated the incident or completed any follow up as of September 10, 2013. [s. 107. (4) 3.]

Issued on this 12th day of September, 2013

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

Rhonda Kukoly