

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

Health System Accountability and
Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
Ottawa ON K1S 3J4
Telephone: 613-569-5602
Facsimile: 613-569-9670

**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
Bureau régional de services de Ottawa

347, rue Preston, 4^{ième} étage
Ottawa ON K1S 3J4
Téléphone: 613-569-5602
Télécopieur: 613-569-9670



February 3, 2012

Ms. Angie Heinz
Administrator
Craiglee Nursing Home
102 Craiglee Drive
Scarborough ON M1N 2M7

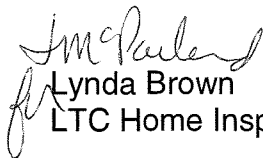
Dear Ms. Heinz:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on December 8, 2011 and January 11, 12, 17, 18, 19 and 20, 2012, 2012 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely


Lynda Brown
LTC Home Inspector – Nurse

c President, Resident's Council
President, Family Council



**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
prévus le Loi de 2007 les
foyers de soins de longue**

Health System Accountability and Performance

Division

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**Division de la responsabilisation et de la
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 8, 2011; Jan 11, 12, 17, 18, 19, 20, 2012	2011_021111_0041	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

LYNDA BROWN (111)

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 the Administrator, the Director of Care (DOC), the Unit clerk, one Registered Practical Nurse(RPN), two Personal Support Workers (PSW) and the resident.

During the course of the inspection, the inspector(s) observed the resident, reviewed the health records and reviewed the homes records.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 230. Emergency plans

(5) the licensee shall ensure that the emergency plans address the following components:
~~4. Specific staff roles and responsibilities~~

Findings/Faits saillants : *(6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information*
 1. Policy (RESI-08-08-03) "Residents Who Wander-Missing Resident" Indicates: (last reviewed December 2002)

1) The missing resident checklist is to be used and to ensure accuracy of documentation, begin report when the Missing Resident Procedure is implemented.

2) The resident search:

-all departments to conduct an organized search of the departments and report findings to charge nurse; if not located, check the facility's exterior grounds and the immediate neighbourhood (by car) within a 4 block radius.

-if the first search fails to locate the missing resident, recheck all areas previously identified,

-notify and maintain contact with: residents family, police, the administrator, the regional director, the physician and the Ministry of Health

The licensee failed to ensure the emergency plans related to missing residents was updated annually, provided specific roles and responsibilities and was complied with. (ref. s.230(5),(6))

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 subsections:

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 failed to provide an identified resident with the treatment, care, services or assistance required for health, safety or well-being, and included a pattern of inaction that jeopardized the health, safety or well-being of the resident.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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).

Findings/Faits saillants :

1. An identified resident with safety risks related to responsive behaviours did not have a written plan of care that set out clear directions to staff and others who provided direct care to the resident.

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 there is a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

- s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
- 1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
 - 2. An unexpected or sudden death, including a death resulting from an accident or suicide.
 - 3. A resident who is missing for three hours or more.
 - 4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
 - 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
 - 6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The Director was not immediately notified for a mandatory report.

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 licensee immediately informs the Director of any resident who is missing for three hours or more, to be implemented voluntarily.

Issued on this 20th day of January, 2012



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
prévus le Loi de 2007 les
foyers de soins de longue

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

Y. Brown



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

Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

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

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2011_021111_0041
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Dec 8, 2011; Jan 11, 12, 17, 18, 19, 20, 2012
Licensee / Titulaire de permis :	CRAIGLEE NURSING HOME LIMITED c/o Deloitte & Touche Inc. - 181 Bay Street, Brookfield Place, Suite 1400, TORONTO, ON, M5J-2V1
LTC Home / Foyer de SLD :	CRAIGLEE NURSING HOME 102 CRAIGLEE DRIVE, SCARBOROUGH, ON, M1N-2M7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANGIE HEINZ

To CRAIGLEE NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:



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

Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

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

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 230. Emergency plans (5) The licensee shall ensure that the emergency plans address the following components: 4. Specific staff roles and responsibilities.
Order / Ordre : (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information.
The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that the homes emergency plans for dealing with situations involving a missing resident is in compliance with applicable requirements under the Act, and is complied with.

The plan must be submitted to Lynda Brown, Long Term Care Home's Inspector, Ottawa SAO by January 27, 2012 via fax # 613-569-9670

Grounds / Motifs :

1. Policy (RESI-08-08-03) "Residents Who Wander-Missing Resident" indicates:(last reviewed December 2002)
 - 1)The missing resident checklist is to be used and to ensure accuracy of documentation, begin report when the Missing Resident Procedure is implemented.
 - 2)The resident search:
 - all departments to conduct an organized search of the departments and report findings to charge nurse; if not located, check the facility's exterior grounds and the immediate neighbourhood (by car) within a 4 block radius.
 - if the first search fails to locate the missing resident, recheck all areas previously identified,
 - notify and maintain contact with: residents family, police, the administrator, the regional director, the physician and the Ministry of Health

The licensee failed to ensure the emergency plans related to missing residents was updated annually, provided specific roles and responsibilities and was complied with.(ref. s.230(5), (6)) (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 07, 2012



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

Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

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

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

Order # /	Order Type /
Ordre no : 002	Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement to ensure all residents are not neglected by the licensee or staff.

The Plan must be submitted to Lynda Brown, Long Term Care Home's Inspector, Ottawa SAO by January 27, 2012 via fax # (613) 569-9670

Grounds / Motifs :

1. The licensee failed to provide an identified resident with the treatment, care, services or assistance required for health, safety or well-being, and included a pattern of inaction that jeopardized the health, safety or well-being of the resident. (111)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Feb 07, 2012



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

Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

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

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is (are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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



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

Order(s) of the Inspector
Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

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des Soins de longue durée**

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of January, 2012

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur :

LYNDA BROWN

Service Area Office /

Bureau régional de services :

Ottawa Service Area Office