Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 18, 2016	2016_342611_0013	011654-16	Resident Quality Inspection

Licensee/Titulaire de permis

955464 ONTARIO LIMITED
3700 BILLINGS COURT BURLINGTON ON L7N 3N6

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

CRESCENT PARK LODGE
4 Hagey Avenue Fort Erie ON L2A 5M5

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

KELLY CHUCKRY (611), IRENE SCHMIDT (510a), ROBIN MACKIE (511)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 10, 11, 12, 16, 17, 18, 19, and 20, 2016.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, menus and clinical health records.

Two additional inspections were completed concurrently with this RQI. One complaint inspection was completed (Log # 015018-16) related to housekeeping, laundry, staffing, and specific care issues, and one Critical Incident inspection was completed (Log # 013061-16) related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument Co-ordinator/Registered Practical Nurse (RAI Co-ordinator/RPN), Registered Dietician (RD), registered staff, Personal Support Workers (PSW's), staff members from housekeeping, dietary and recreation departments, residents and family members associated with the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **5 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	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

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 licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

The home had a Skin and Wound Care Program in place (CN-S-13-1). This program indicated that the home was to have a skin and wound care team. It further described that this team could be a stand alone committee or be incorporated into an inter-disciplinary committee meeting. In addition, one of the objectives of the program was to conduct rounds on high risk residents at least quarterly.

A review of the home's skin/wound/dietary health team meeting agenda confirmed that the home conducted weekly wound care meetings a total of nine (9) times in 2015, and no meetings had taken place in 2016 to date.

An interview with staff #100, #110, and the DOC confirmed the home did not have an active skin and wound care committee and had not conducted meetings or rounds on a consistent basis, and as a result the home has not complied with their Skin and Wound Care Program. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of the home's Continence Care and Bowel Management Program, reviewed by the home in April 2016, indicated that an assessment of a resident's bowel incontinence will be assessed at least quarterly and with any change in health status that affected continence using the MDS RAI assessment Tool.

The MDS-RAI quarterly assessments, Section H for Continence on two identified dates, indicated the bowel continence status of resident #023. A review of the resident's progress notes indicated that the resident had a change in their health status as it related to their bowel continence status for a two month period of time. This resident was sent to hospital on three occasions during this time related to their change in condition. A Resident Assessment Protocol (RAP), dated after the change in bowel continence status indicated this change. An assessment, using the MDS-RAI Assessment Tool for bowel incontinence was not completed when there was a change in the residents health status as indicated above.

The RAI-Co-ordinator/RPN confirmed the MDS-RAI assessment was not implemented as

outlined in the home's Continence Care and Bowel Management Program. [s. 8. (1) (b)]

3. The licensee's Pain management policy CN-P-09-1 dated January 2016 stated that all residents were observed for indicators of pain daily and if a resident has indicators of pain than an assessment would be done. The Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC) tool was indicated as the tool to be completed or if the resident was not cognitively impaired, the cognitive pain assessment in Point Click Care (PCC). The policy also identified that the resident was to be reassessed for pain when there was a change in their condition that impacted pain or caused new pain or if the resident indicated ongoing unrelieved pain.

A review of the plan of care for resident #014 indicated a history of pain, for which they received pain medication, as per the doctors orders, and the registered staff were to note the effectiveness of the pain medication. On an identified date, an incident occurred with this resident.

On an identified date, the resident was documented to complain of not being able to sleep and was experiencing pain. A nursing note stated the resident had complained of pain. The resident was assessed as to the level of pain experienced and pain medication was administered two hours later. During a three day period of time, resident #014 complained of pain on three separate occasions.

An observation of resident #014 during this inspection took place. The resident was observed with an obvious injury. Further review of the clinical record revealed there was a delay in the completion of a pain assessment by a member of the registered nursing staff.

An interview with the DOC confirmed the licensee failed to ensure a pain assessment was implemented as part of the home's pain management program when the resident returned from the hospital from a fall and presented with pain.

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 be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out (c) clear directions to staff and others who provided direct care to the resident.

On an identified date, the care for resident #032 was observed during the day shift. Three transfers were completed for this resident, including the transfer onto the toilet, off the toilet, and the transfer into bed. All three of these transfers were completed with the assistance of staff #123.

The plan of care for resident #032 indicated that transfers were to be provided by the assistance of two people during the day shift. The document the home referred to as the

Kardex in the binder at the resident care station, indicated that transfers were to be provided by the assistance of one person.

Staff #123 clearly articulated that this resident was a one person assistance for transfers, and that was the care that was provided. Staff #111 indicated that two staff members were to assist resident with transfers during the day shift.

An interview conducted with the RAI Co-ordinator/RPN confirmed that the plan of care was updated for resident #032 in March and the updated Kardex was not printed for staff to reference during the provision of care, resulting in clear direction not being provided to staff who provided care to resident #032. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

A review of the clinical record for resident #023 indicated the resident experienced a significant change in status on two occasions. The Substitute Decision Maker (SDM) and Physician were notified. The Physician ordered the resident to be sent to hospital. Resident #023 experienced a significant change in health status that required the services of external services on more than one occasion.

During the quarterly assessment for the period of time that included the residents hospital admissions, a significant change in care requirements occurred. A review of the resident's written plan of care from the period of time in which the resident's condition changed, was not updated. In addition, a significant change assessment was not completed using the Resident Assessment Instrument, Minimum Data Set (RAI-MDS).

An interview with the DOC confirmed a significant change to resident #023's health condition. The DOC confirmed the written plan of care had not been updated when the resident's care needs changed to indicate the current change in the resident's status. The RAI Co-ordinator/RPN confirmed they had not completed a significant change in status in the Minimum Data Set-Resident Assessment Instrument (MDS-RAI) and had indicated the change in status at the next quarterly review. [s. 6. (10) (b)]

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 sets out clear direction to staff and others who provide direct care to the resident and to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at other times when the residents care needs change or when care set out on the plan of care is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A review of resident #014's admission MDS assessment for a specified date indicated under section H Continence, the residents bladder continence status. On an identified date, a bowel and bladder assessment was completed that indicated the resident's level of bladder function, including the status of continence products. The next quarterly MDS assessment, indicated under section H Continence, that the resident had experienced a change in their continence functioning. The resident experienced a new medical condition, and the physician made changes to this resident's medications as a result. There were no further Bowel and Bladder Assessments completed as of May 16, 2016.

An Interview with the DOC confirmed the Bowel and Bladder Assessments Tool as the home's clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. The DOC confirmed the MDS Assessment documented decline in the resident's bladder continence, along with the change to the resident's plan of care would be a condition or circumstance that required further assessment using the home's continence Bowel and Bladder assessment tool. [s. 51. (2) (a)]

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 (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident requires, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home, (a) completed a nutritional assessment for all residents on admission and whenever there was a significant change in a resident's health condition and (b) assessed the matters referred to in paragraphs 13 (nutritional status, including height, weight and any risks related to nutrition care) and 14 (hydration status, and any risks related to hydration) of subsection (3)

A review of the clinical records for resident #023 indicated that a review was completed by the RD on an identified date using the Nutrition / Hydration Risk Identification Tool. This quarterly assessment indicated the resident was at a moderate nutrition/ hydration risk, often refused supplements, and was below their ideal body weight. The RAP for the same period, identified the resident had a change in medication with an identified goal to promote adequate intake, weight maintenance and hydration.

A review of the clinical record indicated the resident became ill on an identified date and had not been eating or drinking well. The SDM and physician were notified. The physician ordered the resident to be sent to hospital. Resident #023 had experienced weight loss and was diagnosed with a health condition.

A Nutrition / Hydration Risk Identification Tool was completed by the RD on an identified date, as a quarterly assessment. This assessment indicated the resident was now at a high nutrition/ hydration risk. The RAP for the same period indicated the resident had been ill, and had not consistently met their hydration needs.

An interview with the RD confirmed that they had seen the resident during the quarter but had not completed a nutritional/hydration risk assessment related to the residents recent change in condition, and hospital admissions. The RD confirmed a Nutrition / Hydration Risk Identification assessment should have been completed, indicating a significant change to the resident, when the resident's condition changed.

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 a registered dietician, who is a member of the staff of the home, (a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition and (b) assesses the matters referred to in paragraphs 13 (nutritional status, including height, weight and any risks related to nutrition care) and 14 (hydration status, and any risks related to hydration) of subsection (3), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, (ii) upon any return of the resident from hospital.

A review of the plan of care for resident #014 indicated they had a risk for impaired skin integrity with risk factors identified. On an identified date, an incident occurred with resident #014 and the resident was taken to hospital. The resident returned to the long term care home with altered skin integrity.

An observation took place with resident #014 during this inspection with obvious injuries noted. Further review of the clinical record did not reveal a skin assessment by a member of the registered nursing staff was completed upon the resident's return from the hospital.

An interview with the DOC confirmed the licensee failed to ensure a skin assessment was completed when the resident presented with altered skin integrity. [s. 50. (2) (a)]

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 (a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, (ii) upon any return of the resident from hospital, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During resident and room observations, three rooms were identified to have a lingering offensive odour.

On May 11, 2016, an identified room on the Macdonald resident home area had a strong smell of urine in the room, as well as the washroom. The same smell was evident again on May 18, 2016.

On May 11, 2016, a second identified room on the Victoria resident home area had a strong smell of urine in the resident's bathroom.

On May 11, 2016, a third identified room on the Victoria resident home area had a strong smell of urine in the resident's bathroom. The same smell was evident again on May 18, 2016.

The above noted observations were not completed after resident toileting, or resident care.

The home had a policy in place titled "Odour Control Policy" dated July 2015. The policy indicated that scent tags and air fresheners are available to put in certain rooms as needed. An interview with staff #194 indicated that these products were not used because of staff sensitivities in the home.

This policy was not fully implemented to address the above noted lingering offensive odours. [s. 87. (2) (d)]

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

Issued on this 8th day of August, 2016

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

Original report signed by the inspector.