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 sions 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
Oct 26, 2016	2016_267528_0021	028888-16	Complaint

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

CYNTHIA DITOMASSO (528)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 6, 7, and 17, 2016

During the course of the inspection, the inspector(s) spoke with the Senior Administrator, Administrator, Director of Care (DOC), registered nurses (RN), registered practical nurses (RPN), healthcare/nurses aides (HCA), residents and families.

During the course of the inspection the inspector observed the provision of care and services, reviewed documents including but not limited to: clinical health record, staffing schedules, policies and procedures, and complaints log.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. The plan of care for residents #010 identified that they were unable to reposition themselves without assistance and required turning and repositioning every two hours. Review of the Turning and Repositioning Record from July to September 2016, revealed that turning and repositioning was not documented for periods of time ranging from five hours to nineteen hours on twenty-three occasions.

B. The plan of care for resident #012 identified that they were unable to reposition themselves without assistance and required turning and repositioning every two hours. Review of the Turning and Repositioning Record from July to September 2016, revealed that turning and repositioning was not documented for periods of time ranging from four hours to thirteen hours twenty-one occasions.

C. The plan of care for resident #013 identified that they were unable to reposition themselves and required assistance of staff with turning and repositioning every two hours. Review of the Turning and repositioning Record from July to August 2016, revealed turning and repositioning was not documented for periods of time ranging from four hours to fifteen hours on twenty-three occasions.

During the course of the inspection, all residents were turned and or repositioned as per their plan of care. Interview with registered staff #108 confirmed that staff turned and repositioned residents #010 #012 and #013 every two hours; however, was not documented consistently as required. [s. 30. (2)]

2. At the end of September 2016, the family of resident #010 reported to registered staff that the resident had a new area of altered skin integrity. Review of the plan of care did not include any assessment of the area. Interview with registered staff #109 confirmed that the resident had a new area of altered skin integrity, which was assessed immediately treated and since healed, but not documented as required. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions is documented, 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Concerns were submitted to the Ministry of Health and Long Term Care that resident #010 was not being provided with incontinent care as required in their plan of care. During the course of the inspection, the resident was observed to be toileted in the morning was transferred out of bed using a mechanical lift, assisted back to bed and provided incontinent care after breakfast, placed back to chair for lunch and transferred back to bed after lunch for continent care and rest in bed.
i. Review of the document the home refers to as the care plan for resident #010 identified that the resident required the assistance of two staff for transfer to bed directly after meals to check the need for incontinent product changes. The care plan also directed staff to change the resident's incontinent product before and/or after meals, at bedtime and if needed when turned and repositioned. The document the home referred to as the kardex directed staff to change the resident's incontinent product before and/or after meals and if needed when turned and repositioned.
ii. Interview with HCA #103 and RN #108 who stated that the resident was to be provided with incontinent care before and/or after meals, at bed time and as needed when turned and repositioned. Interview with HCA #105 and registered staff #101 who stated that the resident was to be transferred to bed directly after meals to checked for wetness and provided with continence care.

The written plan of care did not set out clear directions to staff and others in relation to the directions provided to staff as to how to manage resident #010's incontinence. [s. 6. (1) (c)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant

At the end of September 2016, the family of resident #010 brought forward care concerns to the DOC. Review of the plan of care and interview with staff identified that the resident's care plan was updated, information communicated to staff, and a response letter written to the complainant. However, review of the 2016 Complaints Log did not include a documented record of the complaint, follow up actions, and response to complainants. Interview with the DOC confirmed that the complaint had not yet been added to the Complaints Log. [s. 101. (2)]

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Issued on this 27th day of October, 2016

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

Original report signed by the inspector.