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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 21, 2017	2017_575214_0019	023688-17	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

CATHY FEDIASH (214), CATHIE ROBITAILLE (536), LISA BOS (683)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 1, 2, 3, 6, 7 8, 2017.

Please note: Complaint inspection #000234-17 related to staffing shortages affecting resident's care was conducted simultaneously with the home's RQI inspection #023688-17. Please refer to the RQI inspection report for relevant findings of non-compliance.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Resident Assessment Instrument (RAI) Coordinator; Registered staff; Personal Support Workers (PSW); residents and families. During the course of this inspection, the Inspectors reviewed resident clinical records; reviewed policies and procedures; reviewed medication incidents and meeting minutes; reviewed training records and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Skin and Wound Care

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. 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) An interview with the RAI Coordinator and registered staff #014 confirmed that resident #100 had an identified alteration to their skin integrity that had been present since at least their annual Minimum Data Set (MDS) assessment on an identified date.

A review of identified assessments for altered skin integrity in Point Click Care (PCC) for an identified period of approximately three and a half months, indicated that weekly reassessments of the resident's identified alteration to their skin integrity had been conducted on one identified date. No further assessments using an identified assessment had been conducted for the time period reviewed.

A review of written assessment notes located on the back of an identified paper record were reviewed for an identified period of approximately three and half months. An assessment note dated on an identified date indicted that that the alteration to the resident's skin integrity was present. No further assessment notes on the identified paper record had been conducted for the time period reviewed.

A review of resident #100's clinical record including progress notes for the identified period above was conducted. No documented assessments of the resident's identified alteration to their skin integrity were able to be located.

An interview with the DOC and the RAI Coordinator confirmed that the identified assessment in PCC was the only assessment that was to be used when a resident demonstrated an alteration to their skin integrity.

An interview with the RAI Coordinator and registered staff #003 confirmed that weekly reassessment of resident #100's identified alteration to their skin integrity had not been completed at least weekly by a member of the registered nursing staff, for the time period reviewed.

B) Resident #002 returned from an identified location on a specified date with an identified alteration to their skin integrity. Eleven days later, an identified assessment was completed and indicated that the identified alteration to the resident's skin integrity remained. The next identified assessment completed 12 days later, indicated that the identified alteration to the resident's skin integrity remained at an identified level; however, it also stated that the altered skin integrity had declined to an identified level. The home did not ensure that resident #002 was reassessed at least weekly by a member of the registered nursing staff. (Inspector #536) [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: 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).**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that the 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 was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) Review of the admission minimum data set MDS assessment completed for resident #104 on an identified date indicated that the resident was continent of their bladder. The next quarterly MDS assessment completed for this resident indicated that the resident was occasionally incontinent of bladder.

Interview with the DOC and the RAI Coordinator identified that it was the home's expectation that a Bowel and Bladder Assessment was completed when a resident had a change in their continence status.

Review of the clinical record for resident #104 did not identify an assessment with a clinically appropriate assessment instrument that was specifically designed for continence had been completed when the resident's continence status had changed, which was confirmed by the RAI Coordinator.

B) Review of the quarterly MDS assessment completed for resident #201 on an identified date indicated that the resident was continent of their bladder. The next quarterly MDS assessment completed for the residen indicated that the resident was occasionally incontinent of bladder.

Interview with the DOC and the RAI Coordinator identified that it was the home's expectation that a Bowel and Bladder Assessment was completed when a resident had a change in their continence status.

Review of the clinical record for resident #201 did not identify an assessment with a clinically appropriate assessment instrument that was specifically designed for continence had been completed when the resident's continence status had changed, which was confirmed by the RAI Coordinator. [s. 51. (2) (a)]

2. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

Review of the plan of care for resident #200 identified that they were incontinent of bowel and bladder and directed staff to toilet the resident at identified times.

Resident #200 was observed on an identified date for a period of approximately three hours. During the observation period, the resident was not toileted.

Interview with staff #040 identified that they were assigned to the resident that day. They confirmed that they did not toilet the resident as directed in their plan of care as the home was short staffed and their workload had increased.

The home did not ensure that resident #200's individualized plan to promote and manage bowel and bladder continence was implemented.

PLEASE NOTE: This area of non -compliance was issued as a result of Complaint inspection #000234-17 which was conducted concurrently with the RQI. [s. 51. (2) (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 the 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 is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219.(1) in the area of monitoring residents restrained by physical devices in accordance with O. Reg. 79/10, s. 221.(1) 5, in relation to the following: s. 76.(7) 4.

The Administrator confirmed that 59 staff in the home provided direct care to residents. Training documents provided by the home at the time of this inspection indicated that 49 of 59 direct care staff or 83 percent (%) had received training in the area of monitoring residents restrained by physical devices in 2016. The Administrator confirmed that training documents provided at the time of this inspection identified that not all direct care staff received training in the area of monitoring residents restrained by physical devices in 2016. [s. 76. (7) 4.]

2. The licensee failed to ensure that all staff who provided direct care to the residents received as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219. (1) in the area of continence care and bowel management in accordance with O. Reg. 79/10, s. 221. (1) 3; and in the area of skin and wound care management in accordance with O. Reg. 79/10, s. 221. (1) 2, in relation to the following: s. 76.(7) 6.

A) The Administrator confirmed that 59 staff in the home provided direct care to residents. Training documents provided by the home at the time of this inspection indicated that 50 of 59 direct care staff or 85% had received training in the area of continence care and bowel management in 2016. The Administrator confirmed that training documents provided at the time of this inspection identified that not all direct care staff received training in the area of continence care and bowel management in 2016.

B) The Administrator confirmed that 59 staff in the home provided direct care to residents. Training documents provided by the home at the time of this inspection indicated that 50 of 59 direct care staff or 85% had received training in the area of skin and wound care management in 2016. The Administrator confirmed that training documents provided at the time of this inspection identified that not all direct care staff had received training in the area of skin and wound care management in 2016. (Inspector #214) [s. 76. (7) 6.]

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 all staff who provide direct care to the residents receive as a condition to continuing to have contact with residents annual retraining in accordance to O. Reg. 79/10, s. 219. (1) in the area of monitoring residents restrained by physical devices in accordance with O. Reg. 79/10, s. 221.(1) 5, in relation to the following: s. 76.(7) 4; in the area of of continence care and bowel management in accordance with O. Reg. 79/10, s. 221. (1) 3, in relation to the following: s. 76.(7) 6, and in the area of skin and wound care management in accordance with O. Reg. 79/10, s. 221.(1) 2, in relation to the following: s. 76. (7) 6, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was released from their physical device and repositioned at least once every two hours.

A) On an identified date, the Inspector observed resident #300 who had an identified physical device applied while up in their identified mobility device, for approximately three hours. During the time of observation the resident was not repositioned. Staff #065 when interviewed confirmed that residents with identified physical devices were to be repositioned every two hours and that resident #300 had not been.

B) Review of the clinical record for resident #200 identified that they required an identified physical device when using their identified mobility device for specified reasons.

Resident #200 was observed on an identified date for approximately three hours with an identified physical device applied. During the observation period, the resident was not repositioned by staff.

An interview with staff #040 identified that they had not repositioned the resident until after the Inspector's observation period had ended. They identified that they were short staffed and their workload had increased.

An interview with the DOC identified that it was the home's expectation that residents who used identified physical devices were to be repositioned at least once every two hours.

The home did not ensure that resident #200 was released from their identified physical device and repositioned at least once every two hours. (Inspector #683)

PLEASE NOTE: This area of non -compliance was issued as a result of Complaint inspection #000234-17 which was conducted concurrently with the RQI. [s. 110. (2) 4.]

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 resident is released from their physical device and repositioned at least once every two hours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the

pharmacy service provider.

On an identified date, resident #100 was prescribed an identified medication to be taken at identified times during the day. The medication incident was documented in the Risk Management section. Incident reports that are completed in the Risk Management section have a statement that indicated that the incident report was Privileged and Confidential – Not part of the Medical Record – Do not Copy. The incident report indicated that the resident's specified dose on an identified date, had not been administered. Under immediate actions taken, documentation indicated that the physician was contacted and identified instruction had been received. A review of the medication incident; resident's progress notes and vitals tab in PCC, indicated that no documentation had been included as to the immediate actions taken to assess and maintain the resident's health.

An interview with the DOC and a review of the documentation in the Risk Management section of PCC for this medication incident confirmed that the medication incident had not been reported to the pharmacy service provider. The DOC confirmed that they had been made aware of the medication incident; however, had not signed off on the medication incident in the Risk Management section of PCC until approximately 10 weeks later.

The DOC confirmed that the medication incident had not been documented with a record of the immediate actions taken to assess and maintain the resident's health and had not been reported to the pharmacy service provider. [s. 135. (1)]

2. The licensee failed to ensure that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b).

A review of medication incidents and adverse drug reactions for an identified period of three months, indicated that one medication incident had occurred on an identified date.

A review of the medication incident identified that it had been documented in the Risk Management section in Point Click Care. Incident reports that are completed in the Risk Management section have a statement that indicated that the incident report was Privileged and Confidential – Not part of the Medical Record – Do not Copy. The DOC indicated that the home used the Risk Management section to document medication

incidents that had occurred at the home level and would use the Medication Incident Form that was provided by the pharmacy for medication incidents that occurred at the pharmacy level. A review of the Risk Management medication incident indicated that on an identified date and time, resident #100 missed their identified prescribed medication.

A review of the medication incident identified categories in which the assessor would be able to check off contributing factors that may have led to the incident. A review of the medication incident indicated that registered staff #008 had completed this incident in the Risk Management section in PCC and under the categories Predisposing Environmental Factors; Predisposing Physiological Factors and Predisposing Situation Factors, a box identified as other had been checked off. No further documentation was entered on the medication incident as to what the other factors were. Review of the medication incident and the resident's clinical record identified that a review and analysis of contributing factors, had not been conducted.

An interview with the DOC confirmed that they were aware of the medication incident; however, had not signed the medication incident as reviewed in the Risk Management system until approximately 10 weeks later. The DOC confirmed that an analysis of this medication incident had not been conducted. [s. 135. (2)]

3. The licensee failed to ensure that, (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and any changes and improvements identified in the review were implemented and a written record was kept of everything provided for in clauses (a) and (b).

During an interview with the DOC documentation was provided of the home's quarterly review of all medication incidents since the time of the last review. The DOC indicated that medication incidents are reviewed quarterly at the Professional Advisory Committee (PAC) meetings.

A review of the PAC minutes on an identified date indicated that a specified report in PCC listed four residents that had medication error incidents on identified dates during an identified period of three months. No further information was documented in the minutes regarding the type of medication incident; any contributing factors; details of the incident or any information to reduce and prevent the medication incidents.

A review of the PAC minutes dated five months later, indicated that no documentation regarding medication incidents had been discussed at the meeting. A review of a specified report in PCC indicted that there had been two medication error incidents on identified dates during an identified period of four months. An interview with the DOC confirmed that medications incidents for this time period had not been reviewed.

An interview with the DOC confirmed that a quarterly review of all medication incidents in the home including any changes or improvements since the last time of the last review in order to reduce and prevent medication incidents had not been completed. [s. 135. (3)]

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 every medication incident involving a resident and every adverse drug reaction is (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider; to ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b); and to ensure that (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and any changes and improvements identified in the review are implemented and a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #6: 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:

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

A) Resident #002 returned from an identified location on a specified date with an identified alteration to their skin integrity. On an specified date, a review was completed of the resident's plan of care which the home refers to as the care plan and identified a specified intervention that was put into place on an identified date. During an interview with the RAI Coordinator, they indicated that the resident received the specified intervention on their return from an identified location. A review of the resolved/cancelled care plan identified that the specified intervention had not been added to the care plan prior to the identified date. The RAI Coordinator confirmed that the written care plan had not set out the planned care for the resident until 53 days following their return from an identified location.

B) Resident #300 had an identified physical device. On an identified date a review was completed of the resident's plan of care which the home refers to as the care plan which identified interventions that staff were to complete.

Resident #300 was observed on an identified date for an approximate period of three

hours with a specified physical device in place. During the observation period, the identified interventions had not been completed. At a specified time during the observation, resident #300 was observed by the Inspector to demonstrate specified responses. When asked, resident #300 was unable to tell the Inspector what was wrong.

The RAI Coordinator confirmed that the written care plan had not set out the planned care for resident #300. [s. 6. (1) (a)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A review of resident #100's annual assessment for their MDS coding dated on a specified date, indicated that the resident was coded as having an identified alteration to their skin integrity. A review of the corresponding narrative Resident Assessment Protocol (RAP), completed under the Activities of Daily Living (ADL) RAP and dated on an identified date, indicated that the previous alteration to the resident's skin integrity had healed.

An interview with the RAI Coordinator and registered staff #003 confirmed that resident #100 currently had an identified area of alteration to their skin that had been present since at least their annual MDS assessment and that this assessment was not integrated or consistent and had not complemented each other. [s. 6. (4) (a)]

Issued on this 29th day of November, 2017

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

Original report signed by the inspector.