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
Sep 14, 2018	2018_704682_0017	017221-18	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

AILEEN GRABA (682), KELLY CHUCKRY (611)

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): July 26, 27, 30, 31, August 1, 2, 3, 2018.

The following onsite inquiries were conducted concurrently with the RQI:
004724-18 related to transfers and positioning
008451-18 related to prevention of abuse and neglect
019486-18 related to personal support services, housekeeping, laundry services, safe and secure home, infection prevention and control, resident's Bill of Rights, staffing.

The following complaint inspections were conducted concurrently with the RQI:
008862-18 related to personal support services
004711-18 related to prevention of abuse and neglect
012695-18 related to responsive behaviours
009385-18 related to prevention of abuse, continence, dining and snack service.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Registered Dietitian (RD); Resident Assessment Instrument (RAI) Coordinator; registered staff; Personal Support Workers (PSW); dietary staff; President of Residents' Council; residents and families.

During the course of the inspection, the Inspectors toured the home; reviewed resident health records; reviewed meeting minutes; reviewed policies and procedures; reviewed Critical Incident System (CIS) submissions; complaints log binder, investigative notes, staffing schedules, observed residents and the administration of medications.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
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

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

- **9 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, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10 s.11 (1) (b), the licensee was required to ensure that there was an organized program of hydration for the home to meet the hydration needs of residents. Specifically, staff did not comply with the licensee's policy Hydration Management CD-05-12-1, updated April, 2017, that directs registered staff to refer residents with a fluid intake of less than 1000 milliliters (mls) for five consecutive business days to a registered dietitian (RD):

10. "Residents with a fluid intake of less than 1000mls x 5 consecutive days, are referred to the RD (complete "diet requisition form") indicating fluid intake less than 1000mls."

A) A clinical record review indicated that resident #002 plan of care included adequate hydration by encouraging consumption of a minimum of fluid per 24 hour period. A further record review indicated that on identified dates in 2018 resident's #002 intake was less than 1000mls daily and that there were no dietary referrals created to alert the RD of the decreased fluid intake. During an interview the RD stated that they did not receive any referrals for resident #002 regarding decreased fluid intake.

B) A clinical record review indicated that resident #013 plan of care included adequate hydration by encouraging consumption of a minimum of fluid per 24 hour period. A further record review indicated that from identified dates in 2018 resident's #013 intake was less than 1000ml daily and that there were no dietary referrals created to alert the RD of the decreased fluid intake. During an interview registered staff #100 stated that referrals were not created for the registered dietitian regarding the decreased fluid intake for resident #002 and #013 and staff did not comply with the hydration management policy which is part of the hydration program. [s. 8. (1) (a),s. 8. (1) (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was (a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and (b) an organized program of hydration for the home to meet the hydration needs of residents.

A review of the clinical health records for resident #072 was conducted on an identified date in 2018 and identified their medical diagnosis. The plan of care identified that resident #072 was to receive a specialized diet, texture for all meals, and that this resident required extensive assistance by one staff member for eating meals. On an identified date, resident #072 was in their room, with a visitor at the time of the meal service. This residents visitor noted the meal service arrived at an identified time, but only after the identified visitor inquired about the tray for resident #072. Registered staff #102 confirmed that on an identified date in 2018, resident #072 only received their meal tray after the visitor expressed concern the tray had not arrived. Registered staff #102 further confirmed that this resident would not have received their meal. In an interview conducted with the DOC, it was acknowledged that an organized program of nutrition care and dietary services for the home was not provided to resident #072 to meet their daily nutrition needs.

PLEASE NOTE: This non compliance is as a result of a complaint inspection Log #009385-18, completed concurrently with the homes RQI. [s. 11. (1) (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 there is (a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and (b) an organized program of hydration for the home to meet the hydration needs of residents, to be implemented voluntarily.

WN #3: 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, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of the clinical health records for resident #005 took place. This resident had areas of altered skin integrity. On an identified date in 2018, a Wound Assessment Tool (WAT) indicated resident #005 had an alteration in skin integrity. Progress note documentation identified this resident had an alteration in skin integrity. After review of the weekly skin assessments for resident #005 by registered staff #103, it was confirmed with the inspector that weekly skin assessments were not completed for this resident for the alteration in skin integrity. In an interview conducted with the DOC, it was confirmed that resident #005 did not have their areas of altered skin integrity reassessed at least weekly.

B. A review of the clinical health records for resident #004 took place. This resident had identified alteration in skin integrity. On an identified date in 2018, a WAT indicated resident #004 had an alteration in skin integrity. After review of the weekly skin assessments for resident #004 by registered staff #103, it was confirmed that weekly skin assessments were not completed for this resident for their alteration in skin integrity. In an interview conducted with the DOC, it was confirmed with the inspector that resident #004 did not have their areas of altered skin integrity reassessed at least weekly. [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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that a full breakfast was available to residents up to at least 8:30 a.m. and that the evening meal was served before 5:00 p.m.

It was observed during the course of the inspection the home had meal and snack times posted in the dining room. The supper meal service had two posted seating times, with the first seating at 4:30 PM, and the second seating at 5:30 PM. During an interview with staff #120, and #121, it was confirmed that the home starts the first seating for supper at 4:30 PM, and food is plated and served to residents between 4:30PM and 4:40 PM. Registered staff #102 also confirmed that the first seating of the supper meal service starts at 4:30 PM. In an interview conducted with the DOC, it was confirmed with the inspector that first seating of the supper meal service starts at 4:30 PM, and is subsequently serviced before 5:00 PM.

PLEASE NOTE: This non compliance is as a result of a complaint inspection Log #009385-18, completed concurrently with the homes RQI. [s. 71. (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 a full breakfast was available to residents up to at least 8:30 a.m. and that the evening meal is served before 5:00 p.m, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A review of the clinical health records took place for resident #058. This resident had an order for an oral medication to be administered for an identified frequency and time period. A review of medication incident reports took place, which identified while administering medications on an identified date in 2018, registered staff #102 administered this medication to resident #016. A review of the clinical records for resident #016 confirmed that resident #016 was not prescribed this medication. During an interview, registered staff #102 acknowledged that resident #016 received oral medication that was not prescribed to them. The DOC further acknowledged that this resident received medication that was not prescribed to them. [s. 131. (1)]

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 no drug is used by or administered to a resident in the home unless the drug had been prescribed for the resident, to be implemented voluntarily.

WN #6: 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 clinical record review indicated that resident's #002 plan of care included adequate hydration by encouraging consumption of a minimum of fluid per 24 hour period. A further record review indicated that from identified dates in 2018 resident's #002 intake was less than the minimum included in their plan of care. Dietary assessments regarding resident #002 intake were documented on identified date in 2018 and in the quarterly assessment on an identified date in 2018. During an interview, the RD stated that they reassessed resident's #002 intake on an identified date in 2018 but did not document in the resident's clinical record. The RD stated that they were aware they failed to document their reassessment, actions and the resident's responses to interventions with regards to decreased fluid intake. [s. 30. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (3) is used to assist a resident with a routine activity of living only if; (4) the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Observations on identified dates in 2018 of resident #015 included an application of an assistive device. A clinical record review indicated that the current plan of care, included the assistive device as per family and resident request. Further review indicated that a consent for the assistive device was not documented in the clinical record. Review of the home's Restraints policy CN-R-05-4 dated February 2016, stated that "when a situation has arisen that a PASD or a restraint is being considered, a discussion with the resident or resident's representative if the resident is incapable will occur. The discussion details the risk(s), alternatives considered/tried and why they would be/were ineffective, what is being considered and why it is being considered. The discussion, regardless of the method of contact is documented in the progress notes including the decision of resident or representative". During an interview, registered staff #105 and #100 confirmed that the consent for the assistive device used by resident #015 was not found in the clinical record. The home did not ensure that the assistive device was consented to by resident #015. [s. 33. (4) 4.]

WN #8: 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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

A clinical record review indicated that on an identified date in 2018 resident's #024 visitor reported alleged abuse and neglect of resident #024 by staff to registered staff #105. Further record review of investigative notes indicated that the complainant did not receive a response from the licensee regarding the complaint. During an interview, the Administrator confirmed that they did not respond to the complainant regarding the allegations. The home failed to respond to the person who made the complaint.

PLEASE NOTE: This non-compliance was identified during a complaint inspection log # 004711-18 conducted concurrently during this RQI. [s. 101. (1) 3.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

The licensee failed to ensure that the records of the residents of the home are kept at the home.
A clinical record review indicated that resident's #024 medication administration record (MAR) for an identified date was not available. During an interview, registered staff #100 confirmed that the MAR for the identified date in 2018, was not in resident's #024 clinical record. The home did not ensure that the records of resident #024 were kept at the home.

PLEASE NOTE: This non-compliance was identified during a complaint inspection log # 004711-18 conducted concurrently during this RQI. [s. 232.]

Issued on this 19th day of September, 2018

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

Original report signed by the inspector.