Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 12, 2021 | 2020_575214_0024 | 013080-20 | 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

CATHY FEDIASH (214)

## 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): December 14, 15, 16, 17, 21, 22, 23, 24, and 29, 2020.**

**Please note: This inspection was conducted simultaneously with Critical Incident System Inspection #2020_575214_0023.**

**The following intake was completed during this complaint inspection:**

**Log #013080-20- related to Personal Support Services; Responsive Behaviours; Falls and Medication.**

**During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Resident Assessment Instrument (RAI) Coordinator; Registered Nurses (RN); Registered Practical Nurses (RPN); Personal Support Workers (PSW) and residents.**

**During the course of this inspection, the inspector reviewed clinical health records; meeting minutes; policies and procedures; staff training records; medication incidents and observed the provision of care.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Medication**
**Personal Support Services**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **4 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. A) The licensee has failed to ensure that actions taken in relation to a resident's bathing, were documented.

The resident was to be bathed in a preferred manner, twice weekly.

Documentation for the resident's bathing records had been blank for five of the ten occasions reviewed.

PSW staff indicated they offered bathing to the resident on the five occasions and the resident declined; however, had not documented these actions and had reported to registered staff on two of the five occasions.

The resident's progress notes contained no documentation for the dates identified above.

The DOC indicated staff were to document on the bathing records and when necessary, were to report to registered staff. Registered staff were to document in the progress notes and staff were to take specified actions.

Not documenting actions taken had a potential risk of not identifying whether or not bathing care was provided and did not allow for the interdisciplinary team to follow up and monitor for patterns and trends.

Sources: the resident's care plan, bathing records and progress notes, and interviews with PSW staff #103, 105, 106, 110 and other staff.

B) The licensee has failed to ensure that actions taken as a result of a resident not receiving drugs as prescribed, were documented.

A Medication Incident Report indicated that a resident had an order in place for a prescribed drug and dose to be taken at specified times on a specific date. On this same date, the physician stopped this order and wrote a new order for the same drug and dose, but at a different time of administration.

The registered staff administered the drug at the time identified in the first order on this date and then administered a second dose at the time identified in the new order as when they checked the new order, they misread the order and thought they were to administer a higher dose of the prescribed drug.

The staff indicated they believed they identified the medication error on the same date, and would have assessed the resident when they became aware. The resident's progress notes from this date and three days after, indicated no documentation was present for the medication incident or the assessment of the resident. The staff indicated they should have documented their assessment of the resident following the medication incident and had not.

As a result of not documenting the medication administration incident and the assessment of the resident, this had the potential risk of not establishing the resident's health status at the time the error became known and for continuous monitoring of the resident.

Sources: Medication Incident Report, resident's progress notes and interview with the RPN and other staff. [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 are documented, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident was bathed at a minimum, twice a week by the method of their choice.

The resident's care plan said they were to be bathed in a preferred manner, twice weekly.

Documentation for the resident's bathing records and interviews with staff indicated the resident had not received bathing twice weekly and by the method of their choice, on three of ten occasions reviewed.

As a result, this had a potential risk of not maintaining their hygiene and identification for potential altered skin integrity to have been delayed.

Sources: The resident's care plan, bathing records and progress notes, and interview's with PSW staff #103, 105, 106, 110 and other staff. [s. 33. (1)]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that strategies were developed and implemented for a resident when they demonstrated a responsive behaviour.

PSW staff indicated a resident had a history of an identified responsive behaviour and this behaviour had improved in the past few months. Staff identified interventions that had been successful.

The resident's electronic care plan did not have a plan or strategies and interventions that were specific to this behaviour. The DOC confirmed this.

Not having strategies developed and implemented for this resident's known responsive behaviour did not provide staff with consistent approaches to the resident's care which had the potential risk for increased responsive behaviours; inability to complete care and put the resident at a potential risk for alteration to their health status.

Sources: The resident's care plan, bathing records, and interviews with PSW staff #103, 105, 106, 110 and other staff. [s. 53. (4) (b)]

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**WN #4: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were administered to a resident, as prescribed.

A Medication Incident Report indicated that a resident had an order in place for a prescribed drug and dose to be taken at specified times on a specific date. On this same date, the physician stopped this order and wrote a new order for the same drug and dose, but at a different time of administration.

The registered staff administered the drug at the time identified in the first order on this date and then administered a second dose at the time identified in the new order as when they checked the new order, they misread the order and thought they were to administer a higher dose of the prescribed drug.

The resident's physician orders and interview with the DOC confirmed the day registered staff had completed the first check of the new order and verbally conveyed the change in the order to the afternoon registered staff. The afternoon registered staff had not completed the second check of the order, including transcribing the order, prior to the administration of the resident's drugs. The DOC provided re-education to this registered staff.

As a result of the resident, not receiving their drugs as prescribed, this had the potential risk of the resident having an undesired outcome.

Sources: The resident's Medication Incident Report, physician order's and interview with the registered staff and other staff. [s. 131. (2)]

**Issued on this 19th day of January, 2021**

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

**Original report signed by the inspector.**