Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

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

**Hamilton District**
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

# Original Public Report

**Report Issue Date:** January 3, 2024

**Inspection Number:** 2023-1101-0005

**Inspection Type:**
Critical Incident

**Licensee:** 955464 Ontario Limited

**Long Term Care Home and City:** Crescent Park Lodge, Fort Erie

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Cheryl McFadden (745) | Cheryl McFadden Digitally signed by Cheryl McFadden Date: 2024.01.09 09:52:36 -05'00' |

**Additional Inspector(s)**
Kristen Murray (731)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4, 5, 6, 7, 8, 2023.
The following intake(s) were inspected:

- Intake: #00020885 - 2587-000003-23 –related to prevention of abuse and neglect.
- Intake: #00021718 - 2587-000005-23 –related to prevention of abuse and neglect.
- Intake: #00021735 - 2587-000008-23 –related to prevention of abuse and neglect.
- Intake: #00088497 - 2587-000023-23 –related to falls prevention.
- Intake: #00094166 - 2587-000029-23 –related to prevention of abuse and neglect.

Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

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

**Hamilton District**
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

- Intake: #00094751 - IL-16476-AH/2587-000030-23 – related to Infection Prevention and Control.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was not neglected by the staff of the home.

Ontario Regulations 246/22, s. 7 states that "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

**Rationale and Summary**

On a specified date, a resident rang their call bell due to incontinence. A Personal Support Worker (PSW) arrived to the resident's room and shut off their call bell, without providing continence care to the resident or informing other staff members that the resident required care for incontinence. The resident was found by another PSW incontinent, the resident was embarrassed following the incident.

The home's Abuse and Neglect Policy stated that the home was committed to providing a safe environment where all residents were treated with dignity and protected from neglect, and any form of neglect by any person, whether through deliberate acts or negligence, would not be tolerated. A PSW stated that the resident was found, had rung the call bell over an hour prior to receiving care, and was upset and embarrassed by the situation. The Director of Care (DOC) stated that the resident did not receive the care they required when they rang their call bell.

There was increased risk to the resident related to not receiving the care and assistance required, affecting the well-being of the resident.

**Sources:** CIS 2587-000029-23; Clinical records for a resident, including care plan, task record, and continence assessment; The home's investigation documentation; The home's "Abuse and Neglect" policy (number RC-02-01-01), last reviewed January 2022; Staff file, and interviews with PSW and DOC. [731]

**WRITTEN NOTIFICATION: Reporting to the Director**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the

information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that when an incident of alleged abuse and neglect was identified, it was reported to the Director immediately.

**Rationale and Summary**
An incident alleging abuse and neglect involving a identified resident was reported by staff to management. A CIS report was not submitted to the Director until three days later.

The home's Critical incident Reporting Policy (ON) RC-09-01-06 stated, Inform the MOH Director immediately, in as much detail as is possible in the circumstances, of each of the following incidents in the home.
b. Abuse of a Resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to a Resident.

The Director of Care (DOC) stated this incident was reported late and that they knew the proper process for reporting to the Director.

There was low risk to the resident related to the home not reporting to the Director immediately.

**Sources:** CIS 2587-000003-23, Clinical records for a resident including care plan, progress notes and assessments. The home's investigation documentation; The home's Critical incident Reporting Policy (ON) RC-09-01-06, last reviewed January 2022; Interview with DOC. [745]

## WRITTEN NOTIFICATION: Continence Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)**
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

A) The licensee failed to ensure that a resident, who required continence care products had sufficient changes to remain clean, dry, and comfortable.

**Rationale and Summary**
A Critical Incident System (CIS) report identified that a resident was found in a wet bed. The resident plan of care identified that they required continence care products and checks during the specified shift. The task record documentation for the shift on a specified date was incomplete for both the "toileting" and "bladder" tasks. The home's investigation notes identified that two Personal Support Workers (PSW) did not recall if they checked the resident during second rounds that shift.

The home's Continence Management policy stated that staff were to follow the resident's plan of care and complete all relevant and required documentation. The Director of Care (DOC) stated that the resident did not get changed as required during the night shift on a specified date.

There was increased risk to the resident related to not receiving sufficient changes to remain clean, dry, and comfortable.

**Sources:** CIS 2587-000005-23; Clinical records for resident, including care plan, task record, and continence assessment; The home's investigation documentation; The home's "Continence Management" policy (number RC-14-01-01), last reviewed March 2023; Staff files; and an interview with DOC. [731]

B) The licensee failed to ensure that a resident who required continence care products had sufficient changes to remain clean, dry, and comfortable.

**Rationale and Summary**
A Critical Incident System (CIS) report identified on a specified date, a resident was found at the beginning of the day shift laying in a wet bed and required a full bed change. The Resident plan of care identified that they required continence care products during a specified shift, and they should have been checked routinely for incontinence. The task record documentation for a specific shift was incomplete for both the "toileting" and "bladder" tasks. The home's investigation notes identified that a Personal Support Worker (PSW) did not complete care for the resident because they left to go help another resident.

The home's Continence Management policy stated that staff were to follow the resident's plan of care and complete all relevant and required documentation. The Director of Care (DOC) stated that the resident did not get changed as required on a specific shift.

There was increased risk to the resident related to not receiving sufficient changes

to remain clean, dry, and comfortable.

**Sources:** CIS 2587-000008-23; Clinical records for the resident, including care plan, task record, and continence assessment; The home's investigation documentation; The home's "Continence Management" policy (number RC-14-01-01), last reviewed March 2023; Staff files; and an interview with DOC. [731]

C) The licensee failed to ensure that a resident who required continence care products had sufficient changes to remain clean, dry, and comfortable.

**Rationale and Summary**
A Critical Incident System (CIS) report and the home's investigation documentation identified that on a specific date a resident rang their call bell due to incontinence, a PSW arrived to their room, shut off their call bell and stated they would be back to provide care. The Resident was found later by another PSW, incontinent. The residents plan of care identified that they required continence care products during the specified shift, and they should have been checked routinely for incontinence and clothing changed after incontinence episodes.

The home's Continence Management policy stated that staff were to follow the resident's plan of care. The Director of Care (DOC) stated that the resident did not receive the care they required when they rang their call bell.

There was increased risk to the resident related to not receiving sufficient changes to remain clean, dry, and comfortable.

**Sources:** CIS 2587-000029-23; Clinical records for a resident, including care plan, task record, and continence assessment; The home's investigation documentation; The home's "Continence Management" policy (number RC-14-01-01), last reviewed March 2023; Staff file; and an interview with DOC. [731]