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
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Original Public Report

Report Issue Date: May 28, 2024
Inspection Number: 2024-1101-0001
Inspection Type: Critical Incident
Licensee: 955464 Ontario Limited
Long Term Care Home and City: Crescent Park Lodge, Fort Erie

Lead Inspector	**Inspector Digital Signature**
Erika Reaman (000764)	Erika Reaman Digitally signed by Erika Reaman Date: 2024.06.21 14:57:06 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14-16, 2024

The following intake(s) were inspected:

- Intake: #00104107/Critical Incident (CI) #2587-000039-23 - Resident care and support services.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, 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,

The licensee has failed to ensure that a resident received a skin assessment that was exhibiting altered skin integrity.

Rationale and Summary

On a date in December 2023, a resident exhibited a change in behaviour. The resident subsequently had a change in their skin integrity. Their clinical records did not show an initial skin assessment completed.

A Registered staff confirmed that a skin assessment would be completed on any new skin condition. They also confirmed that a skin assessment was not done for the resident for the identified date.

By not completing a skin assessment on a resident it posed a risk of not identifying a worsening skin condition.

Sources: A resident's clinical records, interview with Registered staff. [000764]

WRITTEN NOTIFICATION: Responsive Behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(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.

The licensee has failed to ensure that actions were taken to respond to the needs of a resident including assessments, reassessments and interventions, and documenting their response.

Rationale and Summary

On a specified date in December 2023, a resident began exhibiting responsive behaviours. The resident was then placed on one to one staffing for safety according to progress notes, and no further follow up documentation was completed related to the resident's behaviours.

The resident subsequently had the same responsive behaviour. There was no documentation to review resident's behaviour during the time of one to one observation.

The Assistant Director of Care (ADOC) acknowledged that there was no charting started on the resident during this time, and that behaviour charting should have been initiated at the start of the one to one staffing.

By not completing behaviour charting on a resident, it posed a risk of not identifying potential triggers for their behaviour.

Sources: A resident's clinical records, interview with ADOC. [000764]