Ontario

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

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

Hamilton District
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Original Public Report

Report Issue Date: July 4, 2024	
Inspection Number: 2024-1101-0003	
Inspection Type: Critical Incident	
Licensee: 955464 Ontario Limited	
Long Term Care Home and City: Crescent Park Lodge, Fort Erie	
Lead Inspector Klarizze Rozal (740765)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20-21 and 25-26, 2024

The following intake(s) were inspected:

- Intake: #00117816 - Critical Incident (CI) #2587-000013-24 related to responsive behaviours

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was re-assessed and their plan of care was reviewed and revised, when the resident's care needs changed.

Rationale and Summary
A resident's written care plan under a specified focus indicated that the resident required a specific intervention. The Director of Care (DOC) acknowledged that the resident's plan of care regarding their specific intervention was not revised and updated accordingly in their care plan when they were assessed and determined they did not require the intervention.

On a specified date, the resident's care plan was revised, and the specific intervention was resolved.

Sources: A resident's clinical records and interviews with staff. [740765]

Date Remedy Implemented: A specified date

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.

A) The licensee has failed to ensure that a resident's responsive behaviour debrief tool, which included an assessment and their responses to interventions were documented.

Rationale and Summary
On a specified date, a resident was sent to the hospital. The DOC acknowledged that a responsive behaviour debrief tool should be completed as per the procedures of their Responsive Behaviour program, specifically for the circumstances when the resident was sent to the hospital.

On review the resident's clinical records, there was no responsive debrief tool completed for the specified date. A registered staff acknowledged they did not complete a responsive behaviour debrief tool on the specified date.

Failure to complete the home's responsive behaviour debrief tool posed a potential risk from identifying and implementing interventions for a resident's behaviours and their responses.

Sources: A resident's clinical records, Responsive Behaviour Policy, and interviews with staff. [740765]

B) The licensee has failed to ensure that a resident's monitoring of their behaviours using the home's Dementia Observation System (DOS) was fully documented.

Rationale and Summary
A resident's plan of care included daily DOS behavioural monitoring for their behaviours. On review, the resident's DOS data collection sheets from specified dates had incomplete documentation on multiple shifts and times. A registered staff acknowledged that the resident's DOS data collection had incomplete documentation.

Failure to complete the DOS data collection sheet of behavioural monitoring posed a risk of not identifying a resident's potential behaviours that may have required intervention.

Sources: A resident's clinical records, Responsive Behaviour Policy, and interviews with staff. [740765]