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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 10/12	2012_072120_0041	Critical Incident

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator and Director of Care regarding 2 critical incidents.

During the course of the inspection, the inspector(s) reviewed identified resident's plan of care and associated care documents/records and the home's policies and procedures on the prevention of abuse and neglect. (H-002550-11/H-000135-12)

The following Inspection Protocols were used during this inspection:

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

An identified resident was not protected from abuse, specifically emotional abuse by a staff member in the home.

In 2011, a witness in the home overheard the resident's care giver yelling at them and threatening them. The resident was very upset thereafter and became quiet and despondent. The witness reported the incidents immediately to management staff. The resident was interviewed shortly thereafter by management staff at which time they noted that the resident's behaviour was not usual. The resident reported that they did not want the care giver to be near them and that the resident was made to feel intimidated, humiliated and fearful of the care giver. The resident explained that the care giver threatened them in several different ways.

The management of the home conducted an investigation and took immediate follow-up action to protect the resident from further abuse by the care giver.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

[O. Reg. 79/10, s.104(1)2.ii] In making a report to the Director under subsection 23(2) of the Act, the licensee did not include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

2. A description of the individuals involved in the incident, including,

(ii) names of any staff members or other persons who were present at or discovered the incident.

A critical incident report which was initially forwarded to the Director in 2011 and amended 2 days later, did not include the names of any staff members or other persons who were present at or discovered the incident involving an identified resident.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care
Specifically failed to comply with the following subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The care, as set out in the plan of care, was not provided to the resident.

On two separate days in 2011, a registered nurse (RN) did not follow the plan of care for an identified resident. The resident's plan of care and doctor's orders both require that the resident's wound be managed by using a specific product to stop drainage or bleeding. On the 1st day, the registered nurse documented that she applied pressure to the resident's wound to stop the bleeding. On the 2nd day, another worker witnessed the RN applying pressure to the wound which caused the resident to cry out in pain. The RN was later questioned by the Director of Care about the required order to use the specified product and the RN admitted that she did not follow the plan of care.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

[LTCHA 2007, S.O. 2007, c.8, s. 24(1)2.] A person who had reasonable grounds to suspect that abuse, specifically emotional abuse, to a resident by another person which resulted in harm, specifically emotional harm, did not immediately report the suspicion and the information upon which it was based to the Director.

A critical incident was not submitted to the Director until 4 days after an incident of emotional abuse against a resident had occurred. An identified resident was emotionally abused by an employee in the home in 2011. A witness reported the incident to management staff immediately, however the management staff did not report their findings to the Director until 4 days later, once they had collected additional information.

Issued on this 31st **day of** May, **2012**

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

B. Susnik