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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 4, 2020	2020_569508_0007	000846-20	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

ROSEANNE WESTERN (508)

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): January 15, 16, 17 and 20, 2020.

A complaint related to a medication error and a change in condition was inspected.

A Critical Incident (CI) inspection, #2020_569508_0008, was conducted concurrently during this complaint inspection.

During the course of this inspection, the inspector toured the facility, observed the provision of care, reviewed resident clinical records and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Physician, the Registered Dietitian (RD), the Resident Assessment Instrument (RAI) Coordinator, registered staff, Personal Support Workers (PSW)s, residents and family members.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's plan of care set out clear directions to staff and others who provided direct care to the resident.

During review of the clinical record for resident #001, specifically, their nutritional plan of care, it was identified that the resident had an objective minimum of fluids per day.

During interview with the Director of Care (DOC), they indicated that the food and fluid intake of all residents are recorded on the resident's Nutritional Flow Chart. The total volume of fluids consumed are totaled every night by staff. The Nutritional Flow Chart directs staff that a dietary referral is required when, fluid intake is below 1000 mls per day over five (5) consecutive days unless indicated otherwise in resident's plan of care.

It was identified that the Nutritional Flow Chart where staff document and review the total volume of fluids consumed did not include what the resident's minimum fluid requirements were.

It was also identified that over an identified period, resident #001 did not meet their minimum required fluid intake. During this inspection, the RAI-Coordinator confirmed that there was no dietary referral submitted and the RD also confirmed they did not receive a referral. During interview with the DOC, the DOC indicated that staff were expected to submit referrals to the RD when residents did not meet their minimum fluid requirements; however, it was not clear to staff what their minimum requirement was.

It was confirmed during review of the clinical records and during interview with the DOC that the plan of care, specifically the Nutritional Flow Chart did not set out clear directions on the resident's minimum fluid requirements. [s. 6. (1) (c)]

2. A review of the resident's clinical record indicated that resident #002 was assessed by the RD in September, 2019, as requiring a specific amount of fluids per day. A review of the resident's January, 2020, Nutritional Flow Chart identified that for an identified period, the resident did not meet their minimum fluid requirements.

It was identified that the Nutritional Flow Chart where staff document and review the total volume of fluids consumed did not include the information on what the resident's minimum fluid requirements were.

During this inspection, the RAI-Coordinator confirmed that there was no dietary referral submitted and the RD also confirmed they did not receive a referral. During interview with the DOC, the DOC indicated that staff were expected to submit referrals to the RD when residents did not meet their minimum fluid requirements; however, it was not clear to staff what their minimum requirement was.

It was confirmed during review of the clinical records and during interview with the DOC that the plan of care, specifically the Nutritional Flow Chart did not set out clear directions on the resident's minimum fluid requirements. [s. 6. (1) (c)]

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 the resident's plan of care sets out clear directions to staff and others who provide care to the resident., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any policy, the policy was complied with. In accordance with O. Reg. 79/10 s.11 (1) (b), the licensee was required to ensure that there was an organized program of hydration for the home to

meet the hydration needs of residents.

Specifically, staff did not comply with the licensee's policy Hydration Management CD-05 -12-1, updated April, 2017, that directed registered staff to refer residents with a fluid intake of less than 1000 millilitres(mls) for five consecutive days to a registered dietitian (RD):
10. "Residents with a fluid intake of less than 1000mls x 5 consecutive days, are referred to the RD (complete "diet requisition form") indicating fluid intake less than 1000mls."

A review of the resident's clinical record indicated that resident #002 was assessed by the RD in September, 2019, as requiring a specific amount of fluids per day. A review of the resident's January, 2020, Nutritional Flow Chart over an identified period of time indicated that the resident did not meet their minimum fluid requirements and also did not meet 1000 mls per day for this identified period.

The RD reviewed the Nutritional Flow Chart for resident #002 and confirmed that they should have received a referral based on the home's policy.

It was confirmed through record reviews and during interview with the RD that the home's hydration management policy had not been complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long term care home to have instituted or otherwise put in place any policy, the policy is complied with. In accordance with O. Reg 79/10, s. 114(2), the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure accurate acquisition, dispensing, receipt and administration of all drugs used in the home.

A complaint was submitted to the Ministry of Long Term Care in January, 2020, regarding a medication error that occurred.

Resident #001 was admitted to the home in January, 2020. Review of the resident's clinical record indicated that the resident started exhibiting responsive behaviours after their admission to the home.

On an identified date, due to the resident's behaviours, staff called the physician and an order was obtained for a medication. The order was to give one tablet, once only by mouth. Review of the Medication Administration Record (MAR) for January, 2020,

verified that the order was transcribed as ordered; however, the resident was administered this medication again over the next two (2) days.

The policy titled, Ordering and Receiving Medication, #4-15, indicated that each resident's medication is packaged in a weekly strip which contains a seven day supply of medication. This policy directed staff to ensure that they compare the weekly strips to the MAR to ensure accuracy. If a weekly pack is missing or any discrepancies are found to contact pharmacy on call immediately.

During interview with the DOC, the DOC indicated that this process is completed by the registered staff on the night shift (2300-0700 hours). During the home's internal investigation, the DOC identified that registered staff #104 had misread the order from the MAR and there for did not realize that this medication should not have been included in the resident's medication pouches.

It was confirmed during interview with the DOC that the Ordering and Receiving Medication policy had not been complied with. [s. 8. (1) (b)]

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 the medication policy instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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. The licensee failed to ensure that actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions were documented.

Resident #001 was admitted to the home in January, 2020.

A review of the resident's plan of care indicated that the resident was a high nutritional risk related to their diagnosis. The Registered Dietitian (RD) assessed the resident as requiring a specific minimum fluid intake per day. PSW staff were required to document all food and fluid intake on the Nutritional Flow Chart and total the amount in the total volume of fluids consumed section.

On several identified dates the resident's intake was not documented.

It was confirmed during review of the resident's clinical records and during interviews with the DOC and the RD that not all food and fluids consumed were documented. [s. 30. (2)]

2. A review of the resident's plan of care indicated that the resident was a high nutritional risk. The Registered Dietitian (RD) assessed the resident as requiring a specific amount of minimum fluid intake per day. PSW staff were required to document all food and fluid intake on the Nutritional Flow Chart and total the amount in the total volume of fluids consumed section.

On an identified date in 2020, the resident was provided a tray which was indicated on the flow chart; however, the intake was not documented. On the same date, the total volume of fluids were also not documented.
On another identified date in 2020, the resident's intake at the hs nourishment and the total volume of fluids consumed was not documented.

It was confirmed during review of the resident's clinical records and during interviews with the DOC and the RD that not all food and fluids consumed were documented. [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 actions taken with respect to a resident under a program, including interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was received by the Ministry of Long Term Care related to a medication error.

Resident #001 was admitted to the home in January, 2020. Review of the resident's clinical record over a specified period of time indicated that the resident started exhibiting responsive behaviours after their admission.

On an identified date, due to the resident's behaviours, staff called the physician and an order was obtained for a medication. The order was to give one tablet, once only by mouth. Review of the Medication Administration Record (MAR) for January, 2020, verified that the order was transcribed as ordered; however, the resident was administered this medication again over the next two days.

It was identified by the Director of Care (DOC) that the pharmacy had packaged the medication as a once daily medication and as a result, registered staff administered two (2) additional doses. The DOC removed the medication pouches, contacted the pharmacy and received new medication pouches with the correct medications. The medication error was then reported to the family and to the physician the same day.

It was confirmed during review of the resident's clinical records and during interviews with the physician and the DOC that the medication was not administered to resident #001 with the directions for use specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 4th day of February, 2020

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

Original report signed by the inspector.