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: June 9, 2023.
Inspection Number: 2023-1101-0003
Inspection Type: Follow up
Licensee: 955464 Ontario Limited
Long Term Care Home and City: Crescent Park Lodge, Fort Erie

Lead Inspector	**Inspector Digital Signature**
Cathy Fediash (214)	Catharine M Fediash Digitally signed by Catharine M Fediash Date: 2023.06.13 13:49:47 -04'00'

Additional Inspector(s)
Phyllis Hiltz-Bontje (129)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 26-27, 2023, and May 1-5, 9-12, 16-17, 19, 2023.

The following intake(s) were inspected:

- Intake: #00017489 - Follow-up #: 1 - O.Reg. 246/22 - s. 18 (1), Compliance Due Date (CDD) February 10, 2023, from inspection #2022-1101-0001.
- Intake: #00017502 - Follow-up #: 3 - FLTCA, 2021 - s. 6 (7), CDD March 16, 2023, from inspection 2022-1101-0001.
- Intake: #00085976 - Follow-up to Compliance Order (CO) #002 from inspection #2021_857129_0010 / 000756- 21, 001523-21 regarding s. 5., CDD July 4, 2022, issued under LTCHA, 2007 S.O. 2007, c.8, s. 101 (4).
- Intake: #00085978 - Follow-up to CO #001 from inspection #2021_857129_0011 / 018849-21, 019426-21 regarding s. 6. (7), CDD June 10, 2022, issues under LTCHA, 2007 S.O. 2007, c.8, s. 101 (4).
- Intake: #00085980 - Follow-up to CO #003 from inspection #2021_857129_0010 / 000756-21, 001523-21 regarding r. 229. (4), CDD July 4, 2022, issued under LTCHA, 2007 S.O. 2007, c.8, s. 101 (4).

- Intake: #00085982 - Follow-up to CO #002 from inspection #2021_857129_0011 / 018849-21, 019426-21 regarding r. 15. (1), CDD June 10, 2022, issued under LTCHA, 2007 S.O. 2007, c.8, s. 101 (4).

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 246/22	s. 18 (1)	2022-1101-0001	#002	Phyllis Hiltz-Bontje (129)
FLTCA, 2021	s. 6 (7)	2022-1101-0001	#001	Cathy Fediash (214)
LTCHA, 2007	s. 6 (7)	Issued as a CO in inspection #2021_857129_0011; then issued as a WN to s. 101 (4) during follow up inspection #2022_1101_0001	#001	Cathy Fediash (214)
LTCHA, 2007	s. 5	Issued as a CO in inspection #2021_857129_0010; then issued as a WN to s. 101 (4) during follow up inspection #2022_1101_0001	#002	Cathy Fediash (214)
O. Reg. 79/10	s. 229 (4)	Issued as a CO in inspection #2021_857129_0010; then issued as a WN to s. 101 (4) during follow up inspection #2022_1101_0001	#003	Cathy Fediash (214)
O. Reg. 79/10	s. 15 (1)	Issued as a CO in inspection #2021_857129_0011; then issued as a WN	#002	Phyllis Hiltz-Bontje (129)

		to s. 101 (4) during follow up inspection #2022_1101_0001		

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home

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)
O. Reg. 246/22, s. 102 (9) (a)

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.

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with any standard issued by the Director with respect to infection prevention and control.

Rationale and Summary
The Infection Prevention and Control (IPAC) Standard for Long-Term Care homes, indicated under section 3.1 (b) to ensure that surveillance is performed on every shift to identify cases of acquired infections.

During an interview, it was identified that residents were monitored for symptoms indicating the presence of infection once per day. One month prior, the home had moved the task of monitoring for symptoms every shift, from a paper document to an electronic document and in doing so, only included the requirement to monitor residents for these symptoms, once daily.

A resident's electronic document had indicated staff were monitoring them for the symptoms of infection, once daily.

The following day, the electronic documents were revised to reflect the need for staff to monitor for symptoms of infection on every shift. Staff confirmed this had been corrected on every resident's electronic document.

Sources: Resident electronic medication administration record, and an interview with the IPAC lead. [214]

Date Remedy Implemented: April 28, 2023

WRITTEN NOTIFICATION: Safe storage of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that prescribed treatments for three residents had been stored in an area or a medication cart, that was secured and locked.

Rationale and Summary
a) Several residents prescription creams were observed to have been left unattended on the top of a personal protective equipment (PPE) cart, which was stored in the hallway in a residential wing.

PSW staff indicated the treatment creams had been put down and forgotten and should have been returned to the registered staff after use.

The DOC confirmed treatment creams were to remain with the PSW and upon completion of the treatment, they were to be returned to the registered staff.

Sources: Observation of resident's prescription creams, the resident's clinical records, including physician orders and electronic treatment administration records, and interviews with PSW staff and the DOC.

b) Following observations of resident prescription treatments having been left on a PPE cart unattended, the DOC confirmed resident prescription creams were stored in a plastic two drawer cabinet, under the desk at the nursing station, when not being used.

Observation of the plastic two drawer cabinet identified two locks, one on each drawer. The drawers were able to open and were not locked. The cabinet was able to be moved from underneath the nursing station desk. The DOC confirmed the cabinet used to store prescription treatments, had not been secured and locked as required.

When drugs are not stored in an area that is secured and locked, this has the potential to compromise the safety of the drug supply.

Sources: Observation of the area used to lock and secure prescribed treatments, and interview with the DOC. [214]

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