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

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Original Public Report

Report Issue Date: September 18, 2023	
Inspection Number: 2023-1101-0004	
Inspection Type: Critical Incident	
Licensee: 955464 Ontario Limited	
Long Term Care Home and City: Crescent Park Lodge, Fort Erie	
Lead Inspector Jonathan Conti (740882)	**Inspector Digital Signature** Jonathan Conti Digitally signed by Jonathan Conti Date: 2023.09.29 15:46:26 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29-31, 2023, and September 5-8, 2023.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake #00006800/CI #2587-000003-22 was related to Medication Management
- Intake #00015180/CI #2587-000019-22 was related to Prevention of Abuse and Neglect

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (1) (c)

The Licensee failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
On a day in March 2022, a resident had a blood glucose reading of an identified value, was conscious, and had signs of hypoglycemia. The nurse attempted to provide an initial intervention to elevate blood sugars but was unable due to the resident's condition. The nurse provided an identified treatment to elevate blood sugars as per the medical directive found in the resident's chart.

As per the Medical Directive signed by the physician, the identified treatment was only to be provided if the resident was conscious with blood sugars less than a specified value. However, at the same time, the medical directive was unclear due to additional information overwritten over it.

The nurse confirmed they misread and followed the old set of medical directives and provided care as they understood the directive.

The Director of Care (DOC) acknowledged the plan of care was not clear to the nurse when they had referred to the medical directive.

By the resident's plan of care having differing medical directives in their chart, there was potential risk of the resident not receiving the appropriate care.

Sources: Resident clinical record; the homes Care of Residents with Diabetes policy (revised February 28, 2020); interviews with the nurse and the DOC. [740882]

WRITTEN NOTIFICATION: Directives by Minister- Binding on licensees

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 174.1 (3)

The Licensee failed to ensure that where the Act required the Licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, effective April 15, 2020, the Licensee was required to ensure that (B) and (C) of the Directive were adhered to: (B) The use of glucagon, and (C) Severe hypoglycemia or unresponsive hypoglycemia, specifically as it relates to the documentation, review, and analysis, and quarterly evaluation sections of the Directive.

Rationale and Summary
On a day in March 2022, progress notes documented that a resident was administered glucagon for severe and unresponsive hypoglycemia where blood glucose level was recorded to be an identified value.

As set out in the Minister's Directive, the licensee was to ensure that all uses of glucagon as well as all incidents of severe hypoglycemia and unresponsive hypoglycemia are reviewed and analyzed, corrective action taken as necessary, and a written record is kept of the review and analysis.

The homes' Care of Residents with Diabetes policy stated that the results of the quarterly evaluations and any changes that were implemented would be recorded in the Professional Advisory Committee (PAC) minutes. The home's PAC meeting minutes did not have evidence of a quarterly evaluation in its entirety as set out in the Minister's Directive.

It was acknowledged by the DOC that there was no documented or formalized analysis of glucagon use nor of severe and unresponsive hypoglycemia incidences for residents as defined in the Minister's Directive and homes' policy.

Sources: Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia (effective April 15, 2020); resident #002 clinic records; the home's policy titled "Care of Residents with Diabetes" (last revised February 28, 2020); PAC meeting minutes; Interviews with DOC . [740882]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe positioning techniques when repositioning a resident in their bed.

Rationale and Summary
A staff member provided turning and repositioning of a resident on their own while the resident was in bed, however, the plan of care for the resident required two staff members for extensive assistance with bed mobility. During the repositioning of the resident, the resident got injured. The resident was sent out to the hospital for an assessment. The resident returned from the hospital the following day without any significant injury or change in status.

The DOC stated that the expectation from the home was that staff members followed the safe transferring and repositioning techniques as per the Safe Resident Handling Policy, and that the staff did not follow this policy nor the bed mobility plan of care requirements for the resident.

By staff not using safe repositioning techniques, the resident sustained injuries.

Sources: Resident clinical records; staff and DOC interviews; staff training records; the homes Safe Resident Handling policy (revised January 2022); the homes internal investigation notes. [740882]