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
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Original Public Report

Report Issue Date: October 25, 2024	
Inspection Number: 2024-1101-0005	
Inspection Type: Critical Incident	
Licensee: 955464 Ontario Limited	
Long Term Care Home and City: Crescent Park Lodge, Fort Erie	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23-24, 26-27, 2024

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

- Intake: #00114673/CI #2587-000010-24 - was related to fall prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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.

The licensee failed to revise the plan of care when there was a significant change in the health status of the resident.

Rationale and Summary

On a specified date, a resident had a fall incident and was transferred to the hospital for further treatment and evaluation. The resident returned from the hospital with a significant change in their health status, and the home implemented a safety check as an immediate fall prevention intervention.

A review of records by the inspector and an interview with the Director of Care (DOC) confirmed that the plan of care was not reviewed and revised with the fall prevention intervention when the resident returned from the hospital.

Sources: Resident's clinical records and an interview with the DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital

The Licensee failed to ensure that an authorized staff completed a skin assessment when the resident returned from the hospital with skin integrity concerns and a significant change in their health status.

Rationale and Summary

On a specified date, the resident returned from the hospital after a fall incident. Registered staff assessed the resident upon return from the hospital and noted skin integrity concerns.

There were no documented records of completed skin assessments by the registered staff when the resident was re-admitted to the home.

The Director of Care (DOC) acknowledged that the registered staff did not complete a skin assessment when the resident returned from the hospital and that it should have been completed.

Sources: Resident's clinical records and an interview with DOC.