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

Public Report

Report Issue Date: March 25, 2025

Inspection Number: 2025-1101-0002

Inspection Type:
Critical Incident

Licensee: 955464 Ontario Limited

Long Term Care Home and City: Crescent Park Lodge, Fort Erie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19-21 and March 24-25, 2025

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

- Intake #00132711/CI #2587-000019-24 - related to Infection Prevention and Control.
- Intake #00133771/CI #2587-000020-24 - related to Prevention of Abuse and Neglect.
- Intake #00134752/CI #2587-000021-24 - related to Medication Management.

The following intake was completed:

- Intake #00138719/CI #2587-000003-25 - related to Infection Prevention and Control.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

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

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

The licensee has failed to ensure that a resident was not neglected by staff in the home.

According to Ontario Regulation 246/22, s. 7, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and include inactions or pattern of inaction that jeopardizes the health, safety or wellbeing of one or more residents.

On a specified date, a resident was not assisted with personal care by a staff member which resulted in the development of altered skin integrity. Management noted that the actions of the staff member constituted neglect.

Sources: The home's investigation notes; staff interview.

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) (b) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident received immediate treatment and interventions to reduce or promote healing and prevent infection to their altered area of skin integrity.

On a specified date, a resident was discovered by staff to have altered skin integrity to an area of their body. The home's internal investigation indicated the staff member was aware of the resident's altered skin integrity on that date, but that they did not report to registered staff. Management acknowledged that the staff member did not follow the home's skin and wound care policy, which resulted in delay of the resident receiving initial treatment and interventions.

Sources: A resident's plan of care; investigation notes; skin and wound care policy; staff interview.

WRITTEN NOTIFICATION: Notification re incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that a resident's substitute decision maker was immediately notified of the outcome of the home's internal investigation regarding alleged neglect of the resident.

When the home completed their internal investigation, the resident's substitute decision maker was not informed.

Sources: A resident's plan of care, investigation notes and interview with management.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
3. A missing or unaccounted for controlled substance.

The licensee has failed to ensure that an incident involving a missing or unaccounted for controlled substance was reported to the Director no later than one business day when the home became aware of the incident. The incident was reported to the Director at a later date.

Management acknowledged that the incident should have been reported to the Director right when staff informed them and that it was not.

Sources: CIS Report; the home's Critical Incident Reporting policy; interviews with staff and management.

WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that registered staff completed controlled medication ward counts between shifts as per the home's policy and procedure.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the Medication Management program is complied with.

Specifically, registered staff did not follow the home's policy or procedure, which resulted in incorrect documentation, and a discrepancy for the medication count of a narcotic not being identified and reported at the time of incident.

Sources: A resident's plan of care; investigation notes; Narcotic/Controlled Ward Drug Count forms; Narcotic and Controlled Drug Count and Ward Count policy; Registered Staff Rules for Counting and Wasting Controlled Medications procedure; interviews with staff and management; CIS Report.

WRITTEN NOTIFICATION: Security of drug supply

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 3.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 246/22, s. 139; O. Reg. 66/23, s.

27.

The licensee has failed to ensure that monthly audits of the daily count sheets of controlled substances were completed.

A review of the home's Monthly Narcotic Audits indicated there were no audits completed in March, June, October, November, or December 2024. Management was unable to provide audits from the listed months.

Sources: Crescent Park Lodge Monthly Narcotic Audits from January 2024 until December 2024; interview with management.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee has failed to ensure that a medication incident involving a resident's missing narcotic was documented and that the resident was assessed following the incident.

On a specified date, a controlled substance was unaccounted for during the controlled medications count for a resident. The home was not able to determine

what happened to the medication. A review of the resident's clinical record did not show documentation related to the medication incident. A medication incident report was not completed until a later date.

Management stated that they should have completed documentation to elude to the incident and to ensure that the resident's medical record was up to date.

Sources: A resident's plan of care; medication incident report; CIS Report; interview with management.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that registered staff reported a medication incident involving a missing narcotic for a resident to the Director of Care (DOC) when they became aware.

Registered staff stated they noticed the narcotic count was incorrect for a resident

on a specified date. Another registered staff member stated they were informed by registered staff of a discrepancy with the narcotic count and stated they did not call the DOC until a later date to report the incident, which was confirmed in a Medication Incident Report.

Management stated if there was a medication incident such as a missing or unaccounted for narcotic, staff were required to report the incident immediately. They acknowledged the incident was not reported to them until a few days later.

Sources: The home's Critical Incident Reporting policy; the home's investigation notes; staff education following incident "Registered Staff Rule for Counting and Wasting Controlled Medications"; interviews with staff and management.