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
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Original Public Report

Report Issue Date: January 16, 2023
Inspection Number: 2022-1101-0001
Inspection Type: Follow-Up
Licensee: 955464 Ontario Limited
Long Term Care Home and City: Crescent Park Lodge, Fort Erie

Lead Inspector	**Inspector Digital Signature**
Phyllis Hiltz-Bontje (129)	Phyllis Hiltz-bontje Digitally signed by Phyllis Hiltz-bontje Date: 2023.01.23 11:50:34 -05'00'

Additional Inspector(s)
Lisa Vink (168)
Stephanie Smith (740738)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 10, 14-16, 21-25, 2022.

The following intake(s) were inspected:

- Intake: #00006241-Follow-up to CO#002 from inspection #2021_857129_0010 / 000756-21, 001523-21 regarding s. 5., CDD Jul 04, 2022
- Intake: #00006791-Follow-up to CO#001 from inspection #2021_857129_0011 / 018849-21, 019426-21 regarding s. 6. (7), CDD Jun 10, 2022
- Intake: #00006795-Follow-up to CO#003 from inspection #2021_857129_0010 / 000756-21, 001523-21 regarding r. 229. (4), CDD Jul 04, 2022
- Intake: #00007104-Follow-up to CO#001 from inspection #2021_857129_0010 / 000756-21, 001523-21 regarding s. 3. (1), CDD Jun 10, 2022
- Intake: #00007105-Follow-up to CO#003 from inspection #2021_857129_0011 / 018849-21, 019426-21 regarding r. 36., CDD Jul 04, 2022
- Intake: #00007133-Follow-up to CO#002 from inspection #2021_857129_0011 / 018849-21, 019426-21 regarding r. 15. (1), CDD Jun 10, 2022

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

Falls Prevention and Management
Infection Prevention and Control
Restraints/Personal Assistance Services Devices (PASD) Management
Staffing, Training and Care Standards

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)
FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of a resident and on the needs of the resident.

Rational and Summary

Signage outside a residents' room identified the resident required specific infection prevention care.

The following day the resident's condition changed, testing was completed, the level of infection prevention care was increased, and precautions were put in place.

The next day signage outside the resident's room was changed, precautions were increased, and a staff member confirmed the additional signage and precautions.

The Infection Prevention and Control (IPAC) lead confirmed the resident did not require the increased precautions, the signage was removed and replaced with a sign that indicated the resident required a lower level of infection prevention precautions.

The Director of Care (DOC) confirmed the signage was to direct staff in the additional precautions to be used.

Failure to ensure that the care set out in the plan of care was based on the assessment of the residents' needs, placed the resident at low risk as the precautions were greater than required.

Sources: Observations of the signage outside of a residents' room, review of progress notes and plan of care, discussion with IPAC lead and other staff.

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Date Remedy Implemented: November 22, 2022

WRITTEN NOTIFICATION: Failure to comply with conditions of CO #001

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 101 (4)

Non-Compliance with: LTCHA s. 101(4)

The licensee has failed to comply with the conditions to which the licensee was subject, identified in a compliance order.

Rationale and Summary
The licensee was subject to the conditions identified in Compliance Order #001 for inspection 2021_857129_0011, related to s. 6 (7) of the Long-Term Care Homes Act S.O. 2007, Chapter 8, served to the licensee on March 14, 2022, which directed the licensee was to be compliant with the conditions of the order on June 10, 2022.

Specifically, the licensee failed to comply with the following:
a) The compliance order required the licensee to conduct audits to ensure directions identified in resident care plans were consistent with the directions for care identified in the Kardex and the Bedside Guide. Auditing was to continue until no further issues were identified and records of the completed audits were to be maintained.

The Director of Care (DOC) provided a "Care Plan/Kardex/Bedside Guide Audit" sheet for residents who resided on one home area. Four handwritten notes on the audit sheet indicated that that care had not been consistent or accurate on the three care direction documents.

The DOC confirmed audits for residents who resided on the second home area had not been completed and auditing had not continued when it was identified the Care Plan, Kardex and Bedside Guide did not contain consistent or accurate information for residents who were audited.

b) The compliance order required the licensee to conduct audits of three residents to ensure falls interventions identified in their plans of care were provided as specified in the plan. Auditing was to continue until no further issues were identified and records of the completed audits were to be maintained.

The DOC confirmed they were unable to provide documentation to verify that falls intervention audits had been completed for the identified residents.

c) The compliance order required the licensee to train all Personal Support Workers (PSWs) on the importance of reviewing the Kardex before each shift when working with a new resident or after a resident had experienced a change in their condition. Training records that included the names of staff who were trained and the date the training was provided were to be maintained.

A training record provided by the DOC showed that seven PSWs had not completed the training prior to the date the licensee was required to be compliant with the order.

A second training record provided by the DOC indicated that 12 PSWs who had received another type of training had not documented that they received the training identified in the compliance order.

The DOC acknowledged they had not completed all the requirements identified in the order.

Sources: CO #001 from inspection #2021_857129_0011, Care Plan/Kardex/Bedside Guide audit record, training sign-in record, CPL training staff list and interviews with DOC.

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WRITTEN NOTIFICATION: Administrator Qualifications

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 249 (3)

Non-compliance with O. Reg. s. 249 (3) (a) (b)

The licensee has failed to ensure the person hired as an Administrator met the requirements to hold the position.

Rational and Summary

Regulation 246/22, s. 249(3) (a) (b) required everyone hired as an Administrator, to have a post-secondary degree from a program that is a minimum of three years duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration, and they must have at least three years working experience in a managerial or supervisory capacity in the health or social services sector.

The Administrator and records provided to the inspector verified they had not met the qualifications to hold the position of Administrator at the time of the inspection.

There was no risk to residents' health, safety, or quality of life when the Administrator did not meet the requirements to hold the position.

Sources: Nursing Department Assistant and Administrative Coordinator job descriptions and interviews with the Administrator.

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WRITTEN NOTIFICATION: Failure to Comply

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 101 (4)

The licensee has failed to comply with Compliance Order (CO) #002 from inspection #2021_857129_0011 served on March 14, 2022, with a compliance due date of June 10, 2022.

The required compliance plan submitted to the Ministry of Long-Term Care (MLTC) to ensure that when bed rails were used, the resident was assessed, and their bed system evaluated in accordance with prevailing practices was not fully implemented.

Rationale and Summary
The home did not develop and implement an interdisciplinary bed safety assessment that included relevant questions and guidance related to the individual resident assessment identified in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings".

The DOC confirmed that the home did not develop and/or implement an interdisciplinary bed safety assessment related to the individual resident assessment. Furthermore, the DOC verified that the licensee's Bed Rails-Safe Use and Entrapment Risk Management policy was not reviewed or revised.

The home was unable to complete formal training for staff, as there was no updated or new policy implemented, nor was there a bed safety assessment created, for staff to be trained on.

Additionally, there was no bed safety assessment completed for three residents or others as there was no updated assessment created or implemented.

The DOC and Administrator were unable to monitor completion of the new bed safety assessment tool, as the new tool was not created or implemented and the DOC and Administrator were unable to implement an action plan if the resident bed safety assessment was not being completed for residents, as there was no bed safety assessment being utilized that they could monitor.

Sources: CO #002 from #2022_857129_0011, the home’s compliance plan (March 2022), interviews with DOC and other staff, resident clinical records, the home's Bed Rails-Safe Use and Entrapment Risk Management policy, and observations.

[740738]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15)

The licensee has failed to ensure that the infection prevention and control (IPAC) lead worked regularly in that position on site at the home, with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

Rational and Summary
Crescent Park Lodge had a licensed capacity of less than 69 beds.
The IPAC lead reported they were scheduled to work on site at the home, two days a week.
Management Payroll Hour records identified that the IPAC lead worked 30 hours bi-weekly and not at least 35 hours bi-weekly.
The home was at risk for assigned responsibilities to not be completed when the staff IPAC lead did not perform that function in compliance with specific IPAC provisions within the Regulations, related to hours of work.

Sources: Review of Management payroll hours and interviews with the IPAC lead and other staff.

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WRITTEN NOTIFICATION: Failure to Comply

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 101 (4)

The licensee has failed to comply with the conditions to which the licensee was subject.

Rational and Summary
A. Compliance Order (CO) #003 from Inspection Report #2021_857129_0010 for Ontario Regulation (O. Reg.) 79/10, section (s.) 229. (4), with a compliance due date of July 04, 2022, was not complied.
i. The licensee failed to conduct daily audits of resident hand hygiene performed before and after snack service as required in the CO.
ii. Training was not provided, and therefore records were not maintained, to all staff, including staff who regularly worked in the home pursuant to a contract with an employment agency, related to the home's policies identified as Surveillance Protocols (CIC-02-18), Pandemic Preparedness and Planning (CIC-04-07), Infection Control Goals and Objectives (CIC-01-02) and Specific Precautions for Infection Control (CIC-03 -02) as required in the CO.
iii. An annual review of the effectiveness of the Infection Prevention and Control Program for 2021, was not conducted as required in the CO and in O. Reg. 79/10, s. 229 (2) (d).

Sources: Review of resident hand hygiene audits, review of Infection Prevention and Control #1 Review

2021 document dated March 28, 2022, and interviews with the Director of Care (DOC), Infection Prevention and Control (IPAC) Lead and other staff.

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B. CO #002 from Inspection Report #2021_857129_0010 for Long-Term Care Homes Act, 2007, s. 5, with a compliance due date of July 04, 2022, was not complied.
The licensee failed to maintain training records for the training provided to all registered nursing staff, including staff who regularly worked in the home pursuant to a contract with an employment agency, related to common and atypical symptoms of COVID-19 in older persons and the actions that must be taken when a resident demonstrated symptoms, as required in the CO.

Sources: Review document titled MOHLTC Compliance Expectation: Infection Surveillance Training for Staff, review of email sent to nursing station on June 3, 2022, and interviews with the Director of Care (DOC) and Control (IPAC) Lead and other staff.

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COMPLIANCE ORDER CO #001 Provision of Care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee is to develop and implement an audit form and an ongoing auditing schedule to be completed on the day and evening shifts to ensure that two residents are provided with care as specified in their plans of care related to resident transfers and fall prevention interventions.

Records of the audits that include the date, time and name of the person who completed the audit are to be maintained in the home for review.

Grounds
Non-compliance with FLTCA 2021, s 6(7)

Rational and Summary

The licensee has failed to ensure that care set out in two residents plans of care were provided as specified in the plan related to a transfer method and interventions to reduce the risk of falls.

a) One resident was not provided with care as specified in their plan of care related to resident transfers and falls prevention care.

   i. The residents' plan of care included a direction that the resident was to be transferred using a specific lift.

      Observation of the resident's room confirmed the specified lift was not available for use and a Personal Support worker confirmed the specified lift was not available and staff used an alternative lift device.

   ii. The resident was observed to be sitting in a chair and a chair alarm was in place.
   A review of the residents' plan of care confirmed the plan did not direct staff that the resident required the use of a chair alarm or that a chair alarm was to be in place on a chair.
   A Registered Nurse (RN) reviewed the residents plan of care and confirmed the plan did not include the use of a chair alarm.

b) A second resident was not provided with care as specified in their plan of care related to the accessibility of their call bell.

   The resident was observed to be in their room, sitting in a chair, the call bell was noted to be attached to the resident's bed and the resident demonstrated they were unable to reach the call bell.

   A review of the residents' plan of care confirmed a care focus related to the risk for falling had been developed and included directions to staff that the resident's call bell was to be accessible to them at all times when in bed or sitting in a chair.
   A RN entered the resident's room at the time of the observation and verified the resident did not have access to their call bell.

There was a risk to the residents' health, safety, and quality of life when they were unable to use the call bell.

[129]

This order must be complied with by: March 2, 2023

COMPLIANCE ORDER CO #002 - Bed Rails

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 18 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

- Implement an interdisciplinary bed safety assessment using relevant questions and guidance related to individual resident assessment, as identified in "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (developed by the US Food and Drug Administration, April 2003 guidance document).
- Ensure three residents are assessed for use of bed rails using the implemented individual resident assessment, and that a record of the assessment is documented within the residents' clinical record.
- Ensure that two of the three residents receive a bed system evaluation, related to entrapment zone testing, and that a record of the evaluation is retained within the residents' clinical record.

Grounds

The licensee has failed to ensure that when three residents used bed rails, the residents were assessed in accordance with prevailing practices, to minimize risk.

Rationale and summary

A document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003", provided the necessary guidance in establishing a clinical assessment where bed rails are used. The guide was cited in another document developed by Health Canada titled “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards”, March 2008. The Health Canada guide was identified by the Director of the Ministry of Long-Term Care in 2012 and 2019, as the prevailing practice with respect to bed safety and shared with the sector.

Two residents used bed rails on the right side of their bed and a third resident used bed rails on both sides of their bed, as indicated in their plans of care. One of two residents received a bed system evaluation related to entrapment zone testing, however, the other resident did not. Additionally, neither resident received a clinical assessment in accordance with prevailing practices. The DOC confirmed that the two residents did not receive a clinical assessment for use of bed rails as there was no assessment implemented.

A third resident was observed to have bed rails raised on both sides of their bed. A PSW and a RN, confirmed that the resident did not have use of bed rails in their plan of care or bedside guide. Additionally, the RN confirmed that the resident did not receive a clinical assessment for use of bed rails in accordance with prevailing practices.

Failure to ensure that residents who used bed rails were assessed in accordance with prevailing practices, could lead to risk of injury and/or entrapment.

Sources: Interviews with DOC and other staff, clinical record review for the three residents, and observations.

[740738]

This order must be complied with by: February 10, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.