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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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: February 24, 2023	
Inspection Number: 2023-1101-0002	
Inspection Type: Complaint	
Licensee: 955464 Ontario Limited	
Long Term Care Home and City: Crescent Park Lodge, Fort Erie	
Lead Inspector Cathy Fediash (214)	**Inspector Digital Signature** Catharine M Fediash Digitally signed by Catharine M Fediash Date: 2023.02.27 13:58:10 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 13, 14, 15, 17, 21, 2023.

The following intake(s) were inspected:

- Intake: #00017705 - related to prevention of abuse and neglect; skin and wound; safe and secure home; resident care and support services; food nutrition, and hydration; recreational and social activities; and housekeeping services.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Recreational and Social Activities

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (iv)

The licensee failed to ensure that a resident's altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A resident was identified on admission to have an alteration to their skin integrity.

Skin and wound assessments indicated the alteration fluctuated over time, from declining, to improving and healing. Record reviews indicated this alteration had re-opened on an identified date.

Record reviews and interviews confirmed the resident's alteration to their skin integrity had not been reassessed weekly by a member of the registered nursing staff, for over a period of seven weeks, and when the alteration was assessed, was found to have declined.

When the pressure ulcer was not reassessed on a weekly basis and monitoring actions were not implemented to ensure completion, this had the potential to contribute to the decline of the pressure ulcer and could have led to a possible decline to the resident's overall health and wellbeing.

Sources: the resident's clinical records including care plan document, assessments and progress notes, and interviews with the DOC and other staff. (214)