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: July 22, 2024
Inspection Number: 2024-1101-0004
Inspection Type: Proactive Compliance Inspection
Licensee: 955464 Ontario Limited
Long Term Care Home and City: Crescent Park Lodge, Fort Erie

Lead Inspector	**Inspector Digital Signature**
Cathy Fediash (214)	Catharine M Fediash Digitally signed by Catharine M Fediash Date: 2024.07.25 11:43:34 -04'00'

Additional Inspector(s)
Lesley Edwards (506)
Lisa Bos (683)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 9, 10, 11, 12, 15, 16, 2024.

The following intake(s) were inspected:

- Intake: #00110520 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management

Food, Nutrition and Hydration
Residents' and Family Councils
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

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)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure that the seven-day and daily menus were communicated to the residents.

Rationale and Summary

Observations and interviews confirmed the correct week of the seven-day menu and no daily menus were posted in the home. During the inspection, the correct seven-day menu and daily menus were posted.

Sources: Observations; interview with dietary staff and the Food Service and Nutrition Manager. [683]

Date Remedy Implemented: July 11, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure that written policies and protocols that had been developed for the medication management system to ensure the accurate storage of all drugs, had been implemented.

Rationale and Summary
The licensee's policy titled, Management of Insulin, Narcotics and Controlled Drugs (last reviewed March 2023, #RC-16-01-13), indicated as per regulatory requirements, narcotics and controlled drugs that were to be destroyed and disposed of, were to be stored safely and securely within the home.

In the presence of registered staff, the inspector observed the container used to store these drugs was full allowing for a drug to be manually removed. Interviews confirmed these drugs were not to be accessible until the time of drug destruction and had not been stored as per the home's policies and protocols. Drug destruction

was completed the following day, resulting in the storage container functioning as intended.

When the safe storage of drugs is compromised, this has the potential for the drugs to go missing and unaccounted for.

Sources: review of the home's policy, Management of Insulin, Narcotics and Controlled Drugs (last reviewed March 2023, #RC-16-01-13), observations of the storage of discontinued narcotics and controlled substances, and an interview with the Director of Care (DOC) and others. [214]

Date Remedy Implemented: July 16, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area.

Rationale and Summary
The home stored their emergency supply of controlled substances requiring refrigeration, in a locked area.

Observation of this area and interviews with the DOC confirmed the controlled substance had not been stored in a double-locked stationary compartment in the

locked area. During the inspection, a locking mechanism was added to the refrigerator.

When controlled substances are not stored in a separate, double-locked stationary cupboard in the locked area, this has the potential risk of the security of the controlled substance drug supply to be compromised.

Sources: Observation of storage of controlled substances, and an interview with the DOC. [214]

Date Remedy Implemented: July 16, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to ensure that a report on the Continuous Quality Improvement (CQI) initiative for the home was posted on their website.

Rationale and Summary
The DOC acknowledged that the home's CQI initiative report for the 2024-2025 fiscal year was not posted to the home's website. During the inspection, it was posted to the website.

Sources: Home's website; interview with the DOC. [683]

Date Remedy Implemented: July 15, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the home's current version of their visitor policy was posted in the home.

Rationale and Summary
In accordance with section 85 (1) of the Fixing Long Term Care Act, 2021, the licensee was to ensure that their visitor policy was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements established by the regulations.

During observations and interviews, it was confirmed the home's visitor policy was not posted in the home. It was posted the same day on the main information board.

Sources: Observation and interview with staff.
[506]

Date Remedy Implemented: July 9, 2024

WRITTEN NOTIFICATION: Exceptions, portable or window air conditioning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23.2 (6)
Uninstalling portable or window air conditioning
s. 23.2 (6) For the purposes of this section, the licensee shall make and keep written records relating to the decision to uninstall the portable air conditioning unit or window air conditioning unit or to not install it, including the circumstances that led to the decision and, where applicable, the date the unit was uninstalled.

The licensee has failed to ensure that written records were kept relating to the decision not to install an air conditioning unit in resident bedrooms.

Rationale and Summary
During an interview, the Administrator acknowledged that almost all of the resident rooms in the home were not serviced by air conditioning, as the residents had not requested it. They confirmed there was no documentation relating to the decision not to install air conditioning units in these resident bedrooms.

Sources: Interview with the Administrator; observations in the home. [683]

WRITTEN NOTIFICATION: Air temperature

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is

maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum of 22 degrees Celsius.

Rationale and Summary
Approximately one month's of the home's internal temperature logs were reviewed. The air temperature was documented below 22 degrees Celsius in various areas of the home, including resident rooms and common areas, on nine days, with temperatures that reached a low of 18.8 degrees Celsius.

There was no documented action taken for the air temperatures that were below 22 degrees Celsius, as confirmed by the Administrator.

Failure to ensure that resident spaces in the home were maintained at a minimum temperature of 22 degrees Celsius had the potential to impact residents' comfort.

Sources: Review of the home's internal temperature logs; interview with the Administrator. [683]

WRITTEN NOTIFICATION: Nursing and personal support services

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that there a written record of the evaluation of their staffing plan that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date those changes were implemented.

Rationale and Summary
In an interview with the Administrator, they acknowledged that the home did not have a written record of the evaluation of their staffing plan.

Sources: Interview with the Administrator; home's staffing plan. [683]

WRITTEN NOTIFICATION: Dining and snack service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that the soup was served at a temperature that was palatable to the residents.

Rationale and Summary
During interviews, five residents on the second seating for the lunch meal service reported that the soup was not warm enough.

Staff indicated that temperature of the soup was taken prior to the first lunch seating, but was not taken prior to the second seating. The FSNM acknowledged that the temperatures of the soup should be taken prior to each seating.

Sources: Point of Service Food Temperature Record; interview with dietary staff and the FSNM. [683]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary
The IPAC Standard, under section 5.6, indicated the licensee was to ensure policies and procedures were in place to determine the frequency of surface cleaning and disinfection, using a risk stratification approach and to ensure that surfaces were cleaned at the required frequency.

The home provided policies and procedures that identified staff were to clean and disinfect surfaces using a risk stratification approach to determine the frequency of

surface cleaning and disinfection.

The Administrator confirmed these policies and procedures had not been implemented at the home and they were unable to demonstrate that surfaces in the home were being cleaned at the required frequency, using this approach.

Failure to implement these policies and procedures had the potential risk of not readily identifying the required frequency for cleaning and disinfecting surfaces in order to minimize the potential of disease transmission.

Sources: the following home's policies and procedures: Environmental Infection Prevention & Control- Routine Practices (effective date of July 9, 2024), Cleaning and Disinfecting Equipment policy (#IC-02-01-11, last updated January 2024), and an interview with the Administrator and others. [214]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (10)
Infection prevention and control program
s. 102 (10) The licensee shall ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 246/22, s. 102 (10).

The licensee failed to ensure that the information gathered under subsection (9), monitoring, and recording of symptoms indicating the presence of infection in residents, was reviewed at least once a month to detect trends, for the purpose of

reducing the incidence of infection and outbreaks.

Rationale and Summary
The Infection Prevention and Control (IPAC) lead indicated the home was unable to provide any documents that identified symptoms indicating the presence of infection in residents, had been reviewed at least once a month to detect trends.

Failure to review symptoms indicating the presence of infection in residents, at least once a month had the potential risk of not identifying trends and patterns to minimize or prevent future symptoms of infections in residents and minimize or prevent outbreaks.

Sources: No documentation available for review, and an interview with the IPAC lead. [214]

WRITTEN NOTIFICATION: Medication management system

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure that written policies and protocols that had been developed for the medication management system to ensure the accurate disposal of all drugs, had been implemented.

Rationale and Summary

The licensee's policy indicated that all narcotic waste was to be witnessed by two nurses and the wastage recorded on the individual resident's Narcotic and Controlled Substances Count Sheet. The College of Nurses of Ontario (CNO) Medication Practice Standard indicated that nurses must comply with employer policies and standards of practice related to the waste of all medication (including controlled substances).

A registered staff indicated they had wasted a medication dose for an identified resident for a specified reason. The resident's Narcotic and Controlled Substances Count Sheet indicated only this registered staff's signature had been documented for the medication wasted, when reviewed later the same day. It was confirmed the expectation was for two nurses to witness and document narcotic wastage immediately upon becoming aware of the need to waste the drug.

When the home's medication management systems protocol was not implemented, it had the potential for the accountability of the resident's identified drug supply to become compromised.

Sources: review of the home's policy, Management of Insulin, Narcotics and Controlled Drugs (last reviewed March 2023, #RC-16-01-13), CNO's Medication Practice Standard, the resident's eMAR and Narcotic and Controlled Substances Count Sheet, and interviews with a registered staff and the DOC. [214]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (c)
Medication incidents and adverse drug reactions

s. 147 (3) Every licensee shall ensure that,
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a written record was kept of any changes and improvements identified in the home's quarter one review of medication incidents.

Rationale and Summary
The home reviewed quarterly medication incidents at their CQI and Professional Advisory Committee (PAC). Review of meeting minutes, that also included the pharmacy's meeting report, indicated medication incidents had occurred during the first quarter of 2024. The meeting minutes and the pharmacy meeting report had not contained any documented information of any changes or improvements the home identified to reduce and prevent these medication incidents. This was confirmed by the DOC.

Failure to keep a written record of changes or improvements had a potential risk of these ideas not being implemented or fully implemented and potentially impacting the ability to evaluate the effectiveness of the changes.

Sources: review of the home's CQI, PAC, and pharmacy meeting minutes and an interview with the DOC. [214]

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.
Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
5. The home's registered dietitian.

The licensee has failed to ensure that the home's Registered Dietitian (RD) was a member of the CQI committee.

Rationale and Summary
In interviews with the RD and the DOC, who was one of the CQI leads, they acknowledged that the RD was not a member of the CQI committee.

Sources: CQI meeting minutes/presentation records; interview with the RD and DOC/CQI lead. [683]

WRITTEN NOTIFICATION: Orientation

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(c) signs and symptoms of infectious diseases;

The licensee has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included (c) signs and symptoms of infectious diseases.

Rationale and Summary
The home used Surge Learning online training to conduct their staff orientation and

re-training for IPAC.

A review of the home's Surge Learning course outline for IPAC training for 2023 and staff IPAC training records for 2023, indicated the training materials had not included signs and symptoms of infectious diseases. This was confirmed by the IPAC lead.

Failure to include this component in staff training, had the potential to result in a delay in identifying potential infections for the purpose of taking timely actions to ensure the well-being of residents and to minimize or prevent further spread of infections.

Sources: Review of the home's 2023 Surge Learning IPAC course outline; review of staff IPAC training records for 2023; and an interview with the IPAC lead. [214]