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: June 18, 2024
Inspection Number: 2024-1376-0002
Inspection Type: Proactive Compliance Inspection
Licensee: 1365853 Ontario Limited
Long Term Care Home and City: Maple Park Lodge, Fort Erie

Lead Inspector	**Inspector Digital Signature**
Lisa Vink (168)	Lisa Vink Digitally signed by Lisa Vink Date: 2024.07.05 14:01:22 -04'00'

Additional Inspector
Cathy Fediash (214)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 28, 29, 30, 31, 2024 and June 3, 4, 10, 11, 2024, and offsite on June 7, 2024.

The following intake was inspected:

- Intake: #00116849 - Proactive Compliance Inspection (PCI).

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
Residents' Rights and Choices
Pain Management
Falls Prevention and 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: FLTCA, 2021, s. 85 (3) (r)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30.

The licensee has failed to ensure that the home's explanation of the protections afforded under section 30 of the Fixing Long-Term Care Act, 2021, regarding whistle-blowing protection, was posted in the home.

Rationale and Summary
The home's whistle-blowing protection policy, which included an explanation of the protections afforded to persons, was not posted in the home. Staff confirmed the policy was not in place and it was posted the same day in the front entrance of the home.

Sources: Observations of the home and an interview with staff. [214]

Date Remedy Implemented: May 28, 2024.

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee has failed to ensure that all doors which led to the outside of the home were locked.

Rationale and Summary
Observations of a service hallway identified an exit door that opened to a non-secured area outside of the home which was not locked.
Staff confirmed this door was not locked as required as the door access control system had been placed on bypass. The staff adjusted the door access control system and locked the door.
When doors that led to the outside of the home were not locked, there was a potential to place residents' safety and security at risk.

Sources: Observations and interviews with staff. [214]

Date Remedy Implemented: May 31, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors which led to non-residential areas were equipped with locks and the doors were kept closed and locked when they were not supervised by staff.

Rational and Summary
Observations of two service hallways included several doors which led to non-residential areas which were open and not supervised by staff; closed with no locking mechanism, or closed and not locked, when not supervised by staff.
When doors that led to non-residential areas were not equipped with locks or were not kept closed and locked when not supervised by staff, residents' safety and security were at risk for harm.

Inspector conducted follow up observations over the course of the inspection and all doors were remedied on or before June 4, 2024.

Sources: Observations of doors and interviews with staff. [214]

Date Remedy Implemented: June 4, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

Rationale and Summary
A cabinet, without a lock, in a resident area contained a bottle of a disinfectant cleaner, which was a hazardous substance.
Staff confirmed the disinfectant was a hazardous substance, was stored in an area that was accessible to residents and immediately removed the product.
When hazardous substances were accessible to residents there was the potential to cause harmful effects to their health and well-being.

Sources: Observations and interviews with staff. [214]

Date Remedy Implemented: May 30, 2024

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to ensure that they sought the advice of the Residents'

Council and the Family Council, in carrying out the survey.

Rationale and Summary
In 2024, the licensee revised questions asked in their Resident and Family/Caregiver Experience Survey and utilized a specific electronic platform to conduct the survey.
Staff confirmed that the advice of the Residents' and Family Council was not sought with the revision of the survey.
There was a risk that questions of importance to the Residents' and Family Councils were not included in the survey when their advice was not sought.

Sources: Review of current Resident and Family/Caregiver Experience Survey and Resident's and Family Council Meeting Minutes as well as interview with staff. [168]

WRITTEN NOTIFICATION: Powers of Residents' Council

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that when the Residents' Council advised them of concerns or recommendations they, within 10 days of receipt of the advice, responded to the Residents' Council in writing.

Rationale and Summary
Residents' Council Meeting Minutes reviewed included examples where members voiced concerns or recommendations and a written response was not provided within 10 days.

Staff indicated that when issues were raised there was a discussion if a formal complaint form was required or not and some comments were managed as staff "reminders" with the support of the membership. Reminders would not include a written response to the council.
Failure to respond in writing to Residents' Council concerns or recommendations within 10 days resulted in incomplete records and had the potential for issues to not be addressed or a misunderstanding of responses provided.

Sources: Review of Residents' Council Meeting Minutes and interviews with a representative of the Residents' Council and staff. [168]

WRITTEN NOTIFICATION: Powers of Family Council

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 66 (3)
Powers of Family Council
s. 66 (3) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

The licensee has failed to ensure that when the Family Council advised the licensee of concerns or recommendations the licensee, within 10 days of receipt of the advice, responded to the Family Council in writing.

Rationale and Summary
Family Council Meeting Minutes identified that not all concerns or recommendations were responded to in writing within 10 days.
Failure to respond in writing to Family Council concerns or recommendations had the potential for issues to not be addressed or a misunderstanding of responses provided.

Sources: A review of Family Council Meeting Minutes and interview with staff. [168]

WRITTEN NOTIFICATION: Retraining

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (4)

Training

s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that all staff at the home received retraining on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary

As per Ontario Regulation (O. Reg.) 246/22, section (s.) 260 (1), the interval for the purposes of subsection 82 (4) of the Act, was annual.

The home conducted annual retraining that included the home's policy for prevention of abuse and neglect of residents.
Staff confirmed, that at the time of the inspection, records supported that not all staff had received the retraining in 2023.
When not all staff receive retraining on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, this had the potential for staff to not recall all aspects of the policy, resulting in the potential of the policy to not be complied with.

Sources: Review of abuse and neglect training records for 2023 and interviews with staff. [214]

WRITTEN NOTIFICATION: Cooling Requirements

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 24 (3)

Air temperature

s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the temperature required to be measured under subsection (2) was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary

O. Reg. 246/22 s. 24 (2) included the requirement to measure air temperatures in one resident common area on every floor of the home.

Maple Park Lodge had resident home areas on both the ground and second floors.
i. The Internal Temperature Log directed staff to take and document temperatures in two resident bedrooms and in one common area in the morning, in the afternoon and every evening.
The log did not direct staff to complete and document temperatures three times a day in a common area on both floors of the home.
Common room temperatures were not taken on both floors three times a day as required.

ii. Internal Temperature Logs identified that temperatures were not consistently documented every afternoon or evening.
There was a risk that staff in the home were not aware that residents were at risk of heat related illness and or a delay in interventions if temperatures were not taken as required.

Sources: Review of May 2024 Internal Temperature Logs and interviews with staff. [168]

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, revised September 2023, 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.
The Provincial Infectious Diseases Advisory Committee's (PIDAC), Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings, 3rd edition, indicated Cleaning Best Practices for Resident Care Areas, using a risk-based approach.
Housekeeping services were provided through a contracted service who provided their own policies and procedures. The company's cleaning procedures for several different areas within the home indicated the procedures in place to determine the frequency of surface cleaning and disinfection, had not used a risk stratification approach.
Staff confirmed the procedures for cleaning and disinfection, had not included the use of a risk stratification approach to determine the frequency of surface cleaning and disinfection.

Failure to include a risk-based approach in the cleaning and disinfecting procedures for the home, had the potential risk of not readily identifying the required frequency for cleaning and disinfecting surfaces to minimize potential disease transmission.

Sources: Review of contracted company's procedures for cleaning, reviewed/revised October 2022; and interviews with staff. [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 has 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
Staff were unable to provide any documents that identified symptoms which indicated the presence of infection in residents, had been reviewed at least once a month to detect trends and confirmed the monthly review was not being conducted.
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, including outbreaks.

Sources: Interviews with staff. [214]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (b)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(b) corrective action is taken as necessary.

The licensee has failed to ensure that for a medication incident corrective actions were initially taken as necessary.

Rationale and Summary
A medication incident occurred.
The incident was immediately reported, and the resident assessed; however, corrective action was not initially taken.
Failure to implement corrective actions, in a timely fashion, had the risk of additional errors.

Sources: Review of clinical records of a resident, medication incident report and investigative notes and interview with staff. [168]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 4.
Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:
4. A written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal year.

The licensee has failed to ensure that their published report on the continuous quality improvement initiative included a description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the priority areas for the next fiscal year.

Rationale and Summary
Maple Park Lodge's Quality Improvement Plan (QIP) Narrative Report was published on their website as their continuous quality improvement initiative report.
The report did not include the required information as set out in O. Reg. 246/22 s. 168 (2) 4 related to their quality program.
Staff confirmed this information was not in the published report or elsewhere on the home's website.

Sources: Review of Maple Park Lodge's website and QIP Narrative Report, dated April 2024 and interview with staff. [168]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,

i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their published report on their continuous quality improvement initiative included a record of, the date the survey required under section 43 of the Act was taken, the results of the survey, and how, and the dates when, the results of the survey were communicated to the residents and their families, Residents' and Family Councils, and staff members.

Rationale and Summary
Maple Park Lodge's QIP Narrative Report was published on their website as their continuous quality improvement initiative report.
The report did not include the required information as set out in O. Reg. 246/22 s. 168 (2) 5 related to their survey.
Staff confirmed the information was not in the published report or elsewhere on the home's website.

Sources: Review of Maple Park Lodge's website and QIP Narrative Report, dated April 2024 and interview with staff. [168]

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.
Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their published continuous quality improvement report included a written record of the dates the actions were implemented and the outcomes of the actions taken in response to improvement in the home, care, services, program and goods based on the results of the survey taken under clause 43 (5) (b) of the act; any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes; the role of the Residents' and Family Council in actions taken under subparagraphs i and ii; the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii; or how, and the dates when, the actions taken under subparagraphs i and ii were

communicated to residents and their families, the Residents' and Family Councils and staff members.

Rationale and Summary
Maple Park Lodge's website included their QIP Narrative for Health Care Organizations in Ontario.
The report did not include the required information as set out in O. Reg. 246/22 s. 168 (2) 6 related to their quality program.
Staff confirmed the information was not in the published report or elsewhere on the home's website.

Sources: Review of Maple Park Lodge's website including QIP workplan and interview with staff. [168]

WRITTEN NOTIFICATION: Training and Orientation

NC #016 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 signs and symptoms of infectious diseases.

Rationale and Summary
A review of the 2023 IPAC training and training records indicated the materials and records did not include signs and symptoms of infectious diseases, as confirmed by staff.

Failure to include signs and symptoms of infectious diseases 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 minimize or prevent further spread.

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

WRITTEN NOTIFICATION: Training and Orientation

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)
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,
(d) respiratory etiquette.

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 respiratory etiquette.

Rationale and Summary
A review of the home's IPAC training for 2023 and training records indicated the materials and records had not included respiratory etiquette, as confirmed by staff. Failure to include respiratory etiquette in staff training, had the potential to result in an increased transmission of infectious diseases.

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