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: December 19, 2024

Inspection Number: 2024-1376-0004

Inspection Type:
Critical Incident

Licensee: 1365853 Ontario Limited

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 19-22, 2024

The following intake(s) were inspected:

- Intake: #00117791 - Prevention of Abuse and Neglect.
- Intake: #00121028 - Fall Prevention and Management.
- Intake: #00122367 - Prevention of Abuse and Neglect.
- Intake: #00131415 - Prevention of Abuse and Neglect.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident was treated with dignity and respect.

Rationale and Summary
During a previous inspection, a resident made a report to an Inspector that they had experienced care that made them uncomfortable and violated. This was reported to the home by the Inspector during that inspection and the home completed an investigation.

The Assistant Director of Care (ADOC) acknowledged that this incident did not treat the resident with respectful and dignified care.

Failure to ensure that the resident's rights were respected made them feel upset and violated with the care they received.

Sources: Resident's clinical records, home's investigation notes, CI report, interview with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that a resident's treatment was documented.

Rationale and Summary
A resident was ordered to receive a specified treatment. This was ordered to be documented by a Registered Practical Nurse (RPN) or a Personal Support Worker (PSW). An interview with the resident and a PSW indicated that they received this specified treatment daily. The PSW indicated that they did not document this treatment application. Review of the resident's records did not show documentation for this.

The Administrator acknowledged that there was no documentation of this specified treatment for the resident.

Failure to ensure that the resident's specified treatment was documented led to the risk of incorrect records and not being able to identify how often the resident was provided treatment.

Sources: Resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A) The licensee has failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident immediately reported this suspicion to the Director.

Rationale and Summary
On a specified date, an altercation occurred between two residents. A resident sustained an injury as a result. A Critical Incident System (CIS) report was submitted to the Director the following day, for resident-to-resident physical abuse. No after-hour submission report was completed. The ADOC acknowledged that reporting to the Director for suspected abuse was to be done immediately and that did not occur in this situation.

Sources: CIS report, residents' clinical records, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting Policy, and an interview with staff.

B) The licensee has failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident resulted in harm or risk of harm to the resident immediately reported this suspicion

to the Director.

Rationale and Summary
On a specified date, an altercation occurred between two residents in which a resident sustained injury. A CIS report was submitted to the Director for resident-to-resident physical abuse two days later. No after-hour submission report was completed during review. The ADOC acknowledged that reporting to the Director for suspected abuse was to be done immediately.

Failure to report incidents of suspected abuse immediately to the Director, put the residents at risk for harm and abuse.

Sources: CIS report, residents' clinical records, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting Policy, and an interview with the ADOC.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A) The licensee has failed to ensure that a resident's responsive behaviour debrief tool, which included an assessment and their responses to interventions were documented.

Rationale and Summary
On a specified date, a resident had an altercation with another resident, which resulted in an injury. The ADOC acknowledged that a responsive behaviour debrief tool should be completed under Point-Click-Care (PCC) assessments, as per the procedures of their Responsive Behaviour program. On review of one of the resident's clinical records, there was no responsive behaviour debrief tool completed related to this incident or any progress notes under the Behaviour Incident note to indicate a debrief was conducted.

Failure to complete the home's responsive behaviour debrief tool posed a potential risk from identifying and implementing interventions for the resident's behaviours and their responses.

Sources: Residents' clinical records, Responsive Behaviour Policy, and interviews with the ADOC.

B) The licensee has failed to ensure that a resident's risk management and responsive behaviour debrief tool, which included an assessment and their responses to interventions were documented.

Rationale and Summary
On a specified date, a behavioural incident involving an altercation between residents occurred. As a result of the incident, a resident sustained injuries by the other resident. The ADOC acknowledged that a risk management incident report and responsive behaviour debrief tool should be completed as per the procedures of their Responsive Behaviour program. On review of the residents' clinical records, there was no risk management report and responsive behaviour debrief tool completed for this incident.

Failure to complete the home's responsive behaviour debrief tool and risk management posed a potential risk from identifying and implementing interventions

for the resident's behaviours and their responses.

Sources: Residents' clinical records, Responsive Behaviour Policy, and interviews with staff and ADOC.

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 (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 has failed to ensure that the home's policy related to the use of topical creams by direct care staff was implemented.

In accordance with O.Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that the medication management policies were complied with.

Specifically, the home did not comply with the policy "Transfer of function/Delegation of Tasks-Topical Creams", revised March, 2023, which was included in the licensee's medication management system.

Rationale and Summary
A resident was ordered to receive a topical treatment cream. There was a reported incident by the resident where a PSW applied this topical treatment cream not as ordered.

The home's policy tiled " Transfer of Function/Delegation of Tasks-Topical Creams"

indicated that the home was responsible to ensure that all direct care staff were competent to safely carry out a restricted activity, which included applying any topical medication within a body orifice. It further detailed that the direct care staff was required to demonstrate initial competency to the nurse who is providing direct supervision prior to completing an assigned/restricted activity.

An unidentified PSW administered the resident's topical treatment cream not as ordered. The Administrator acknowledged that the policy was not followed and the PSW staff had not completed the initial competency demonstration to the nurse.

Failure to ensure that PSW staff followed policy on application of topical treatment creams led to this medication not being applied properly.

Sources: Resident's clinical records, home's policy titled "Transfer of Function/Delegation of Tasks-Topical Creams", and interviews with a resident and Administrator.

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that medication for a resident was kept secured and locked.

Rationale and Summary

A resident was ordered to receive a specified medication as needed. This medication was observed to be in an unsecured area in the resident's room. The ADOC indicated that this medication was to be stored in a specified area in the resident's room and locked in that designated area.

Failure to ensure that the resident's medication was stored properly had risk for resident safety.

Sources: Observation of medication, interview with the ADOC.