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: February 24, 2025
Inspection Number: 2025-1376-0001
Inspection Type: Complaint 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): February 11-12, 14, 18-21, 24, 2025
The inspection occurred offsite on the following date(s): February 13, 2025

The following intake(s) were inspected:

- Intake: #00131968 -Critical Incident (CI) # 2891-000029-24 - Related to infectious disease outbreak.
- Intake: #00132876 -CI # 2891-000030-24 - Related to prevention of abuse and neglect.
- Intake: #00132917 - Complainant with concerns related to prevention of abuse and neglect.
- Intake: #00132923 - Complainant with concerns regarding skin and wound care.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

The IPAC Standard for Long-Term Care Homes revised September 2023, s. 9.1 (d) states the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program, specifically proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal.

On a specified date, a staff member was observed entering two resident rooms donning a surgical mask instead of an N95 mask. Contact/droplet isolation signage on both resident doors instructed staff to donn an N95 mask, eye protection, gloves, and a gown before entering the room.

Sources: Observations of PPE donning/doffing; isolation signage on resident doors; resident's plan of care; interview with IPAC Lead.

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