Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 6, 2021	2020_640601_0024	021097-20, 021664-20, 023917-20	Critical Incident System

Licensee/Titulaire de permis

Crown Ridge Health Care Services Inc.
106 Crown Street Trenton ON K8V 6R3

Long-Term Care Home/Foyer de soins de longue durée

Crown Ridge Place
106 Crown Street Trenton ON K8V 6R3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): Dates of inspection: December 7, 8, 9, 10, 11, 14, 15, and 16, 2020.

The following intakes were completed in this Critical Incident System (CIS) Report Inspection:

A log related to an unexpected death.

A log related to a fall that resulted in a change in condition.

A log related to a medication incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeper, and residents.

The inspector also reviewed resident health care records, applicable policies, observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's electronic Medication Administration Record (e-MAR) set out clear directions to registered staff administering the resident’s medication.

A resident was prescribed a medication to manage a medical condition and they experienced a specified episode. During this time, the resident had refused breakfast four times, lunch three times and dinner five times.The physician prescribed to hold the specified medication, if the resident didn’t eat their meal and reassess at next meal.

On a specified date, the resident had eaten less than 50 percent of their breakfast and refused lunch. The RPN assessed the resident’s medical condition as stable at lunch time and the resident received the specified medication. The resident experienced a specified episode prior to dinner.

The RPN indicated they were not aware the resident had a prior specified episode or that the physician had prescribed to hold the specified medication, if the resident did not eat their meal. The RPN indicated the e-MAR did not display the directions to “hold if resident does not eat meal”. The RPN indicated they didn’t know they were supposed to click on the medication order to view further directions. The RPN also indicated they

should have held the specified medication when the resident did not eat their lunch.

The DON indicated that the RPN had assessed the resident prior to administering the medication. According to the DON, the physician's order was not clear, as the written order included the directions to "reassess at next meal" and the RPN had assessed the resident's using a specific test prior to giving the medication at lunch time.

There was actual harm when the resident received the specified medication at lunch time when they had not eaten their meal. The e-Mar was not clear when it did not display the entire directions, and the RPN was not aware there was an extra step to complete when reading the e-MAR directions for administering the resident's specified medication at lunch time.

Sources: Documentation Survey Report, a resident's e-MAR, physician's orders, progress notes and interview with RPN and the DON. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with the resident's physician or Nurse Practitioner (NP) and each other in the assessment of a resident after the resident's fall so that their assessments were integrated, consistent with and complemented each other.

A Resident had a fall and the resident sustained an injury. The head injury routine was initiated for the resident. The Nurse Practitioner (NP) assessed the resident and prescribed to contact the NP or physician, if the resident's condition worsened. The resident was transferred to another facility some days later for assessment and it was determined the resident had a specified injury.

The resident's electronic Medication Administration Record (e-MAR) indicated the resident had received their as needed pain management medication during the specified period of time.

The resident's progress notes indicated the resident had complaints of specified symptoms and a change in condition following their fall.

Personal Support Workers interviewed indicated that the resident was spending more time in bed and required increased assistance with care after they fell. The resident was reporting discomfort with repositioning. Registered staff indicated the resident required pain medication, as needed after they fell to manage their pain. Registered staff indicated

they did not notify the NP or physician regarding the resident or their pain management. The NP indicated they had assessed the resident's after their fall, and they were not made aware the resident's condition had worsened following their fall.

The licensee's Head Injury Routine Form policy directed to call the physician immediately, if the resident experienced specified symptoms. The resident sustained actual harm when they fell and registered staff did not collaborate with the NP or physician when the resident's condition worsened.

Sources: The licensee's Head Injury Routine Form policy, a resident's e-MAR, progress notes, Documentation Survey Report, and interviews with two PSWs, RPN, RN, and the NP. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident and to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

Issued on this 8th day of January, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.