Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 29, 2015	2015_280541_0022	O-002280-15	Resident Quality Inspection

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

AMBER MOASE (541), BARBARA ROBINSON (572), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 6-15, 2015

Three Critical Incidents were conducted concurrently with this RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, Wound Care Coordinator, Clinical Care Coordinator, Environmental Services Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers, Family and Resident Council Presidents, Family Members and Residents. In addition inspectors also reviewed resident health care records, observed resident meal service, observed medication passes and reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **0 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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was afforded afforded privacy in treatment and in caring for his or her personal needs.

On July 13, 2015 during the observation of the noon medication pass RPN staff member #S118 was observed administering insulin in the exposed abdomen to Resident #39 while the resident was sitting at a table in the dining room with 2 co-residents.

RPN #S118 indicated to Resident #39 that insulin would be administered in three injections today as there was not an insulin pen for the full dose therefore a third pen is required for part of a dose. Resident #39 objected with "ow" when given the injection to which RPN #S118 replied to the resident "come on we do this every day" and laughed.

During an interview with RPN #S118 he/she confirmed that he/she always administers insulin in the dining room.

On July 13, 2015 RPN staff member #S106 was interviewed and indicated that insulin is to be administered in the resident's room. [s. 3. (1) 8.]

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

A review of the health care record for Resident #3 indicates that the Resident has multiple co-morbidities including impaired mobility that poses a high risk for falls. The Resident has had five falls in the past six weeks.

The Resident's Care Plan from a specified date, indicates that Resident #3 utilizes a Hi-Lo bed and clip alarm when in bed to prevent falls. The current Care Plan with a specified date, for Resident #3 directs staff to "Use fall prevention equipment equipment as available at bedside ie. gym mats, bed/chair alarms, Hi-Lo bed in low position" without specifying which equipment to use. The posted "Logo" for Resident #3 at the bedside directs staff to use a bed alarm. The worksheet provided for PSWs states that a clip alarm on the bed is to be used, as well as the bed is to be at knee level.

In an interview on July 9, 2015, RN #S102 said that Resident #3 does not use a bed alarm as the noise prevented the resident from sleeping. PSW #S104 and PSW #S105 noted that Resident #3 has not used a clip alarm for approximately three weeks, and does not use a bed alarm. All staff interviewed indicated that a Hi-Lo bed is in use.

The plan of care for Resident #3 was not revised to reflect the falls prevention interventions that are in place nor to reflect those interventions that have been discontinued. [s. 6. (10) (b)]

2. A review of the health care record for Resident #19 indicates that the Resident has multiple co-morbidities including osteoporosis and a previous fracture that has resulted in impaired mobility that poses a high risk for falls. The Resident has had six falls in June, 2015, eight falls in May, 2015, and four falls in March/April, 2015.

The Resident's Care Plan from a specified date, indicates that Resident #19 utilizes a clip alarm when up in chair and a bed alarm at night. The current Care Plan with a specified date, for Resident #19 directs staff to "Use fall prevention equipment equipment available at bedside ie. gym mat, bed/chair alarms, Hi-Lo bed in standard position" without specifying which equipment to use. The posted "Logo" for Resident #19 at the bedside directs staff to use a clip alarm with a date from 2014. The worksheet provided for PSWs states that a clip alarm on chair/bed is to be used. In addition, a Physical Restraint Assessment from a specified date in 2015 states that Resident #19 has not had a trial of a Hi Lo bed or a fall mat, and has a clip alarm.

In an interview on July 13, 2015, PSW #S115 and PSW #S116 said that Resident #19 does not use a clip alarm as the resident removes it, but uses a bed alarm. RPN #118 confirmed that Resident #19 does not use a clip alarm, and the resident was observed on three days without a clip alarm during the day. All staff interviewed indicated that a Hi-Lo bed is in use.

The plan of care for Resident #19 was not revised to reflect the falls prevention interventions that are in place nor to reflect those interventions that have been discontinued. [s. 6. (10) (b)]

3. The licensee has failed to ensure that different approaches were considered when care set out for a particular resident was not effective.

A review of the resident's health care record indicates that Resident #35 has multiple medical issues including a pressure ulcer.

The progress notes indicate that for over a three month period in 2015 the status of the wound did not improve with increased margins and increased drainage. The treatment

dressing protocol did not change.

In interviews on July 9 and 10, 2015, RPN staff members S#106 and S#108 stated the wound has not improved.

On July 09, 2015 the wound care coordinator S#107 confirmed that the wound remains unstageable.

The plan of care for Resident #35's treatment dressing was not changed when it was identified that the wound was not improving.

On July 13, 2015 the Administrator confirmed that the wound was identified as a wound that did not improve with the ongoing treatment regime. As a result the treatment regime is being re-evaluated and revised. [s. 6. (11) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system related to the falls program was complied with.

In accordance with O. Reg. 79/10 s. 30 (1)1. and O. Reg. 79/10 s.48 (1)1, the licensee is required to have a falls prevention and management program that that includes a written description of the program that includes goals, objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor

outcomes.

The home's policy "Falls Prevention and Management" (NPPM: 4.1, last updated April, 2014, page 4) describes Post-Fall Management procedures. Number 6 states that staff are to "Monitor the resident for 72 hours after a fall and document".

Resident #3, who had 5 falls in the past 6 weeks, did not have documentation post-fall for 72 hours after falls on two specified dates.

In an interview on July 15, 2015, Clinical Care Coordinator #S111 and the Administrator acknowledged that the home's policy that details post-fall management procedures was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system related to the falls program was complied with.

Resident #19, who had 14 falls in a 2 month period did not have documentation post-fall for 72 hours after falls on six specified dates.

In an interview on July 15, 2015, Clinical Care Coordinator #S111 and the Administrator acknowledged that the home's policy that details post-fall management procedures was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that the policy for receipt of controlled medication was complied with.

In accordance with O. Reg. 79/10 s.114(2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Log # O-002117-15
On a specified date, a Critical incident was submitted to the Ministry of Health and Long-Term Care Re: Controlled Substance missing/unaccounted for.

The Critical Incident report indicated the following:

On a specified date an RPN attempted to re-order a controlled medication for a resident

and was informed that the order had been delivered three days prior.

The RPN and RN supervisor were unable to locate the missing medication despite paperwork confirming the medication was received on the specified date.

Policy No. NPPM: 9.5 b "Receiving Controlled Medication form Pharmacy :

Policy: To ensure the proper receipt and storage of controlled drugs into the home.

Procedure:
3. The nurse receiving the delivery will take the following steps:
-inspect the bag and ensure tamper resistant seal is intact
-open seal and remove medication
-check delivered medications match the Controlled Medication Delivery sheet
-Nurse to sign acceptance of delivery
4. a copy of the Controlled medication delivery Sheet will be faxed to the pharmacy to indicate receipt of the controlled drug
5. A Controlled Drug Administration sheet will be initiated by the Registered staff member who received the controlled drug for in house control record.

On July 13, 2015 during a telephone interview with RN S#120 it was confirmed that the medication receipt protocol was not completed as the appropriate paperwork regarding receiving the medication, initiating a controlled drug administration form to control and record the medication and secured appropriately.

On July 14, 2015 during an interview with the Administrator and review of the Receiving Controlled Medications policy it was confirmed that the policy was not complied with. The Administrator confirmed the missing medication was not located. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the inspection:
• Room 47- Lower area of the bathroom door noticeably scarred, wood chipped, entrance flooring in both right and left corners has lifted away from the sub-floor, centre flooring approximately 1' x 2" has lifted causing a bubbled area.
• Room 2- Floor is lifting and bubbled in both corners at entrance to room, also a slightly raised area in the center of the floor approximately10”x2” where the flooring has lifted
• Spa Room, East Wing- Flooring around the shower drain is cracked and taped, tap to the stationery tub has rust visible.
• Spa Room, North Wing- Large shower area flooring floor surrounding the shower drain is damaged, 8”x12” cut is lifted and rusted. Base board heater noticeably dented, paint is chipped and gouged. Toilet bowl has multiple brown calcium like stain deposits surrounding inner rim. Corner strapping cracked approximately 2”x5”, lower corner missing exposing steel frame, corner flooring behind the entrance door lifting, adjoining flooring at the entrance of the shower has a seam that has lifted x 3”. Flooring along the right wall of the walk in shower room has lifted away from the concrete, flooring along the left side of the tub area has 4’ long strip missing ½ inch wide along the wall exposing concrete. Sink /vanity has a piece of strapping missing approximately 2”x 2” ion the left corner.
• Ridgeway Common Areas- Door frames at entrance to sunroom on both sides have large 6” and 4” areas with missing plaster and exposed steel frame. Carpet trim in this area torn away from the wall, paint is noticeably chipped and scarred. Doors that are noticeably scarred through the middle of the doors exposing wood. Baseboard heaters on the left wall as well as top heater have visible black marks and dents. Entrance area to the kitchenette has gouge marks on outside edge of wooden door frame.

The Environmental Services Manager stated during an interview on July 14, 2015 that that home currently has a system of ongoing preventative and remedial maintenance which includes monthly maintenance plans.

Not maintaining the home, furnishings and equipment in a safe condition and a good state of repair presents potential risks to the health, comfort, safety and well-being of residents. [s. 15. (2) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature at the home is maintained at a minimum 22 degrees Celsius.

On July 8, 2015 during an interview with Inspector #541, family member of Resident #1 indicated that the common lounge on Ridgeway (secure) unit can feel cold in the winter.

Inspector #541 noted the following readings from the digital thermometer at the nursing station on Ridgeway unit:
- 19.4 degrees C (July 7, 2015)
- 20.6 degrees C (July 13, 2015)
- 21 degrees C (July 14, 2015)

It is noted the nursing station on Ridgeway unit is a small, open concept area that includes a desk located in the middle of the unit. The nursing station is an area where residents are commonly wandering around and the temperature taken in this area is reflective of the hallway temperature of the unit.

On July 13, 2015 Inspector #541 interviewed Environmental Services Manager (ESM) staff member #S114 who indicated there are temperature log books at the East, Georgian and Ridgeway nursing stations where the air temperatures are to be recorded on the day, evening and night shifts. ESM staff member #S114 indicated staff are to use the digital thermometers located behind the nursing stations to record the air temperatures. ESM staff member #S114 indicated if the temperature is below 22 degrees C, maintenance is to be notified.

The temperature log sheets on Ridgeway unit were reviewed for May, June and July 2015. The following recorded temperatures were noted:
- 20.0 – 21.2 degrees C (five recordings between July 1-6, 2015)
- 20.1-21.6 degrees C (nine recordings between June 1-16, 2015)
- 21-21.5 degrees C (two recordings between May 1-16, 2015)

Inspector #541 interviewed ESM staff member #S114 on July 13, 2015 who indicated maintenance was not notified when the air temperature on Ridgeway unit was recorded below 22 degrees C.

ESM staff member #S114 indicated policy ESMM 5.1 dated June 2015 is being reviewed and will be implemented to ensure staff members are aware of the process to monitor air temperatures. [s. 21.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of a missing or unaccounted for controlled substance.

Re: Log # O-001729-15:
A Critical Incident report (CIR) was received by the Director on a specified date. The CIR indicated that eight days prior to the CIR submission, it was noted that an Emergency stock card containing 30, 1m Dilaudid tablets was unaccounted for.

On July 13, 2015 an interview with the Administrator indicated the Director was not notified for seven days when the Critical incident report was submitted. [s. 107. (3) 3.]

2. The licensee has failed to ensure that the Director was informed of an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident.

Re: Log #O-002427-15
On a specified date, Resident #45 was being monitored closely as the resident recovered from an upper respiratory infection. The Resident was found on the floor in his/her bedroom at 0500 hrs after he/she had self-transferred out of bed to get a drink despite having fluids at the bedside. The progress notes document that a call was made to the hospital on the date of the fall to determine the status of Resident #45. The Resident had sustained a fracture, and the notes reflect that the home's managers were notified of this diagnosis the same date. The Critical Incident not submitted to the Director until two business days after the occurrence of the incident. [s. 107. (3) 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
(a) all expired drugs; O. Reg. 79/10, s. 136 (1).
(b) all drugs with illegible labels; O. Reg. 79/10, s. 136 (1).
(c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and O. Reg. 79/10, s. 136 (1).
(d) a resident's drugs where,
(i) the prescriber attending the resident orders that the use of the drug be discontinued,
(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or
(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128. O. Reg. 79/10, s. 136 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the medication management system, the written policy provides for the ongoing identification and disposal of all expired drugs.

On July 13, 2015 observation of the medication drug storage area in the East Wing confirmed the following medications as being expired:
-Olanzapine 5 mgm 10 tabs expiration date July 1, 2015 (emergency supply)
-Warfarin 3 mgm 10 tabs expiration date April 2015 (emergency supply)

The home identifies expired medications via quarterly audits completed by the pharmacist as well as an internal process whereby the clinical care coordinator and duty nurse check the medications for expiration dates on a monthly bases and sign to indicate the medication was checked. This process is not included in the written policy.

The clinical care coordinator S#111 confirmed during an interview that the internal monthly review was not completed in April or May, 2015.

On July 13, 2015 during an interview with the Administrator and review of the "Disposal of Surplus Medications" policy she confirmed that the policy does not provide for the identification of expired drugs. [s. 136. (1)]

Issued on this 29th day of July, 2015

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

Original report signed by the inspector.