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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Aug 26, 2016	2016_195166_0025	013449-16	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

CAROLINE TOMPKINS (166), JULIET MANDERSON-GRAY (607)

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): August 15, 16, 17, 18 and 19, 2016

Critical Incidents log# 012772-16 related to an incident requiring transfer to hospital and a significant change in a resident's status, log# 019915-16, related a medication incident and complaint log #018377-16, related to resident care were also inspected

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President and Co-President of the Residents' Council, Personal Support Workers, Physiotherapist , Assistant Physiotherapist, Life Enrichment Coordinator, Registered Nurses, Registered Practical Nurses, Nutritional Manager and the RAI Coordinator.

During the course of this inspection the inspectors toured resident home areas and common areas, observed staff to resident interactions during the provision of care. Observed a medication administration, reviewed clinical health records , the licensee's investigations documentation, Resident Council meeting minutes and the licensee's policies related to admission information and medication administration.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
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

During the course of this inspection, Non-Compliances were issued.

2 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	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 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. related to log 019915-16

The licensee has failed to ensure that any policy or system instituted or otherwise put in place is complied with.

The Long Term Care Homes Act, 2007-O. Reg 79/10. r. 114.(1) requires that every licensee of a long term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The licensee's policy NPPM:9.6, Routine for Administration of Medication/Treatment, indicates:
The RN/RPN must always remain with the Resident until all the medication/treatment is taken . Never leave medication with a Resident to take unsupervised by a registered staff.
A Critical incident report was received reporting that resident #045 may have ingested medication that was to be administered to resident #046.
Medications had been mixed in with liquid and was to be administered by the registered staff to resident #046..

Review of licensee's investigation indicated RPN #107, turned away from the table, where the liquid containing the medication was placed and did not watch if resident #046 had consumed all of the liquid containing the medication.
Other staff members then noticed that resident #045 held an empty glass that when last observed was 1/3 full and contained medication prescribed for resident #046.
Therefore the licensee's policy related to medication administration was not followed. [s. 8. (1) (b)]

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 a registered staff member(RN or RPN) must always remain with the resident until all the medication/treatment is taken and ensure that medication is not left with a resident to take unsupervised by a registered staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate actions are taken in response to any medication incident involving a resident.

A Critical Incident Report(CIR) was received reporting resident #045 may have ingested medications mixed in a liquid that was to be administered to resident #046.
The glass when last observed had 1/3 of liquid remaining. Resident #045 was not observed by staff taking or consuming the liquid containing the medication . Resident #045 was observed by staff holding an empty glass that had contained the liquid and resident #046's medications.
Resident #045, was assessed by the RN.and the resident was transferred to the hospital for further assessment.

Review of clinical documentation and interview with RN #105, RN #106 and the Administrator indicated that resident #046 was not assessed for the potential adverse symptoms of not receiving the prescribed amount of medication.
Therefore appropriate actions were not taken in response to the medication incident which also involved resident #046. [s. 134. (b)]

Issued on this 26th day of August, 2016

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

Original report signed by the inspector.