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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 22, 2017	2017_589641_0037	009557-17	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

CATHI KERR (641), DARLENE MURPHY (103), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 14, 15, 16, 17, 20 and 21, 2017.

The following critical incident logs were also inspected: Log #024409-17 and Log #026029-17 related to residents falling resulting in an injury and Log #026417-17 related to a resident sustaining an injury resulting in a change of health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the RAI Coordinator, the Office Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Maintenance staff, the Resident Council President, residents and residents' family members.

During the course of the inspection, the inspectors conducted a tour of the home, observed medication administration and written processes for handling of medication incidents and adverse drug reactions, dining services, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident council minutes, the home's staffing schedules for the nursing department, and policies and procedures related to falls prevention.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug was prescribed for the resident.

The Director of Care (DOC) was interviewed in regards to the home’s process for documenting medication incidents. She indicated the registered staff member that discovers the error documents the details of the error on a medication incident form and makes the appropriate notifications. Upon completion of the form, the registered staff member submits it to the DOC who then reviews the incident and takes action to address the error with the staff member responsible.

The inspector requested to review the home’s medication incidents for a specified three month period. A total of eleven incidents were provided to the inspector for that period of time. The three most serious incidents were reviewed in depth.

The first incident involved resident #006. On a specified date, the resident was given in error another resident’s medications. The resident was monitored following the error and there were no untoward effects noted as a result of this error. The Administrator and the DOC provided coaching to the registered staff member responsible. [s. 131. (1)]

2. The licensee has failed to ensure drugs were administered to residents in accordance with the directions for use specified by the prescriber.

As outlined above, medications incidents were reviewed for a specified three month period. The second incident reviewed involved resident #044. On a specified date, the registered staff discovered that the physician's orders related to a medication that the resident had received the day before had not been followed. The DOC coached the registered staff in response to the error.

The third incident reviewed involved resident #043. On a specified date, the physician ordered to hold all oral medications for this resident until further assessment by the nurse practitioner. One day later, the registered staff member administered an oral medication to resident #043 despite the order to hold the medications. The resident suffered no ill effects as a result of this error. The DOC counseled the registered staff that contributed to this error. [s. 131. (2)]

Issued on this 22nd day of November, 2017

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

Original report signed by the inspector.