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
Jul 14, 2020	2020_640601_0011	002186-20, 002504-20, 002652-20, 002768-20, 003096-20, 009880-20, 009985-20, 011151-20	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): June 29, 30, July 2, 7, and 8, 2020.

The following intakes were completed in this Critical Incident Report Inspection:

Five logs related to falls that resulted in a significant change in condition.

One log related to allegations of staff to resident abuse.

One log related to medication administration.

One log related to missing items.

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

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's care set out in the plan of care was provided to the resident as specified in the plan related to falls prevention.

Inspector #601 reviewed a Critical Incident Report (CIR) that was submitted to the Director on a specified date and time, it was reported there was an alleged improper treatment of resident #001, by PSW #110 that resulted in a specified injury. The CIR indicated that on a specified date and time, RPN #108 heard resident #001 fall and discovered that PSW #110 had not applied resident #001's specified safety device.

Review of resident #001's written plan of care related to their risk for falls and falls prevention, by Inspector #601. Resident #001 required the specified safety device for a specified reason.

Inspector #601 reviewed resident #001's progress notes and on the specified date, RPN #108 documented that resident #001 was assessed after their fall and the specified safety device was not in place.

During separate interviews, RPN #108 and PSW #113, indicated to Inspector #601 that resident #001 was at risk for falls for a specified reasons. RPN #108 and PSW #113 both indicated the resident's written care plan directed to ensure that resident #001's specified safety device was in place. According to RPN #108, PSW #110 had provided resident #001's personal care prior to their fall, on the specified date and it was determined post fall that resident #001's specified safety device was not in place.

During an interview, the Administrator indicated that resident #001 should of had the specified safety device in place, as specified in the resident's written care plan.

The licensee failed to ensure the written plan of care for resident #001 was followed on the specified date, when the resident fell and the specified safety device had not been applied by PSW #110, as specified in the resident's written care plan. [s. 6. (7)]

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 residents care set out in the plan of care is provided to the resident as specified in the plan related to falls prevention, to be implemented voluntarily.

WN #2: 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. (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 drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

A Critical Incident Report (CIR) was received by the Director on a specified date related to allegations of resident neglect due to medication not being administered as prescribed.

Review of resident #010's physician orders by Inspector #601, identified that on a specified date, the physician had prescribed a specified medication with regular dosing, for a specified symptom.

Review of resident #010's Medication Administration Record (MAR) by Inspector #601, identified that on two specified dates, RN #104 documented the resident was sleeping and the specified medication was not administered to the resident, as prescribed by the physician.

Review of resident #010's progress notes by Inspector #601, identified that RN #104 documented on the two specified dates that resident #010 did not receive the prescribed specified medication, as the resident was sleeping and there was no indication the resident was in distress or was experiencing the specified symptom.

During a telephone interview, RN #104 indicated to Inspector #601 that resident #010 was prescribed the specified medication to manage a specified symptom. RN #104 indicated they should have woken the resident on the two specified dates to administer resident #010's specified medication, as prescribed by the physician.

During separate interviews, the Director of Nursing (DON) and the Administrator indicated to Inspector #601 that resident #010 was experiencing the specified symptom and RN #104 should have attempted to wake resident #010 on the two specified dates in order to administer the resident's specified medication, as prescribed by the physician.

The licensee failed to ensure that drugs were administered to resident #010 in accordance with the directions for use specified by the prescriber when the resident did not receive their specified medication on two specified dates, as prescribed by the physician. [s. 131. (2)]

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 drugs were administered to residents in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

Issued on this 22nd day of July, 2020

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

Original report signed by the inspector.