Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
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Amended Public Report (A1)

Report Issue Date: November 22, 2022
Inspection Number: 2022-1278-0001
Inspection Type: Critical Incident System
Licensee: Crown Ridge Health Care Services Inc.
Long Term Care Home and City: Crown Ridge Place, Trenton

Inspector who Amended	**Digital Signature of Inspector who Amended**
Julie Dunn (706026)	

AMENDED INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect a required administrative change to the report. There is no change to the narrative of the findings/grounds or the determination of compliance.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 20-21, 24-27, 31, 2022

The following intake(s) were inspected:

- Intake: #00003120- related to the fall of a resident resulting in injury.
- Intake: #00004179- related to the fall of a resident resulting in injury.
- Intake: #00006115- related to the fall of a resident resulting in injury.
- Intake: #00003031- related to a resident a change in health status, requiring transfer to hospital.
- Intake: #00002200- related to the fall of a resident resulting in injury.
- Intake: #00002823- related to the fall of a resident resulting in injury.
- Intake: #00006120- related to the fall of a resident resulting in injury.

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The following **Inspection Protocols** were used during this inspection:

Medication Management
Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

FLTCA s. 6 (7) The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
A resident fell and sustained injuries.
The plan of care for the resident identified them as high risk for falls and stated to follow specified Falls Prevention measures. During four separate observations, it was noted that the resident did not have one of the specified Falls Prevention measures in place. A staff member stated that certain Falls Prevention tools are used in the long-term care home, and staff use the logo sheets posted above resident beds to see which Falls Prevention measures are to be applied. A staff member stated that they must have forgotten to apply the Falls Prevention tool for the resident. The Director of Nursing (DON) stated the home's expectations are for the Falls Prevention measures to be applied.

By not applying the Falls Prevention tool, the staff were not providing the care specified for the resident related to Falls Prevention, and there may be increased risk of falls for the resident.

Sources:
Observations of resident; review of resident's plan of care plan and logo sheet; interviews with staff and DON.

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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure the implementation of the infection prevention and control (IPAC) standard issued by the Director. Specifically, Requirement 9.1 of the IPAC Standard, related to ensuring that signage was posted at the entrance to residents' rooms or bed space, indicating enhanced IPAC measures were in place for residents on Additional Precautions; and Requirement 10.1 of the IPAC Standard, related to ensuring the hand hygiene program included access to alcohol-based hand rub (ABHR) with 70-90% alcohol.

Rationale and Summary:
A list of residents on Additional Precautions was reviewed. Throughout the dates of the inspection, there were no signs for Additional Precautions observed on the entry doors of the resident rooms who were identified to be on Additional Precautions. The IPAC Lead and DON both stated that if a resident is on Additional Precautions, the expectation was for signage to be posted at the resident's door, with any Additional Precautions listed.

There were observations of ABHR dispensers labelled 60% alcohol in dining rooms, on medication carts and at the COVID-19 rapid testing table at the main entrance to the long-term care home. The ABHR labelled 60% alcohol was observed to be used by staff to assist residents in two dining rooms with hand hygiene prior to lunch and used by staff for their hand hygiene between interactions with residents. The IPAC Lead stated they were aware that they had ABHR dispensers with 60% alcohol and that did not meet the requirement of 70% alcohol, as stated in the IPAC Standard.

Failing to ensure access to ABHR with 70-90% alcohol for hand hygiene at point of care, and failing to ensure that signage was posted at the entrance to residents' rooms for residents on Additional Precautions, may have lead to increased transmission of disease.

Sources:
Interviews with IPAC Lead and DON; Observations of dining rooms, COVID-19 rapid testing area, and medication carts; Record reviews of the list of residents on Additional Precautions, and resident's clinical record.

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