



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

**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**

Ottawa Service Area Office  
347 Preston St, 4th Floor  
OTTAWA, ON, K1S-3J4  
Telephone: (613) 569-5602  
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa  
347, rue Preston, 4<sup>ième</sup> étage  
OTTAWA, ON, K1S-3J4  
Téléphone: (613) 569-5602  
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**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité**

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Apr 16, 2014	2014_348143_0005	O-000258- 14	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**

PAUL MILLER (143), AMBER MOASE (541), BARBARA ROBINSON (572)

**Inspection Summary/Résumé de l'inspection**



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

**This inspection was conducted on the following date(s): April 7th to 11th and April 14th, 2014.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, the Life Enrichment Coordinator, the Environmental Manager, nursing administrative staff, the President of the Resident Council, the President of the Family Council, the Nutritional Care Manager, dietary aides, residents and family members.**

**During the course of the inspection, the inspector(s) observed resident care and services, completed tours of all resident home areas, reviewed policies and procedures, reviewed resident health care records, observed dining service, medication administration, reviewed Resident Council and Family Council minutes of meetings, infection control practices and reviewed Registered Staff schedules.**

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

**Accommodation Services - Housekeeping  
Contenance Care and Bowel Management  
Dining Observation  
Falls Prevention  
Family Council  
Food Quality  
Infection Prevention and Control  
Medication  
Minimizing of Restraining  
Nutrition and Hydration  
Pain  
Personal Support Services  
Residents' Council  
Skin and Wound Care  
Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**



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1. The Licensee has failed to comply with LTCHA, 2007, s.8(3) whereby a registered nurse who is both an employee of the licensee and a member of the regular staff of the home was not on duty and present in the home at all times, except as provided for in the regulations.

Crown Ridge Place is a 116 bed long term care home. During the Resident Quality Inspection, it was noted that the home has not ensured that at least one registered nurse is on duty and present in the home at all times.

Registered Nurse (RN) schedules were reviewed from March 10th to April 20th, 2014 with the Acting Director of Care (ADOC). During that time, the home did not have a RN working on 6 night shifts for the hours from 2300 hours to 0700 hours. The ADOC stated the home used a Registered Practical Nurse to fill the vacant shifts.

The identified shifts not being covered by an RN are not the result of an emergency or a planned or extended leave of absence as outlined in the regulations. Therefore, the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff are not applicable as per Ont. Reg 79/10 s. 45 (2). [s. 8. (3)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council**

**Specifically failed to comply with the following:**

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

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**Findings/Faits saillants :**



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1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 57 (2) in that the licensee did not respond in writing to the Resident Council within 10 days of receiving a concern or recommendation.

On April 11th, 2014 Inspector #572 reviewed the Resident Council minutes for January, February and March 2014. At the February 10th, 2014 meeting the Resident Council raised four concerns and recommendations related to resident care. There is no evidence to support that a written response from the licensee regarding these four resident care issues was provided to Resident Council.

On April 11th, 2014, the President of the Resident Council indicated during an interview with Inspector #572 that she did not recall receiving any written responses within 10 days to the four concerns or recommendations raised by Council at the February 10th, 2014 meeting. Responses by the licensee to concerns or recommendations are addressed at the next monthly Council meeting. The four issues were discussed at the March 10th, 2013 meeting and the licensee's responses were recorded in the minutes.

On April 11th, 2014, the Resident Council Assistant (S106) confirmed that a written response to concerns or recommendations was not provided within 10 days to the Resident Council. [s. 57. (2)]

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

**Specifically failed to comply with the following:**

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

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**Findings/Faits saillants :**



**Ministry of Health and  
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1. The licensee has failed to comply with LTCHA ,2007,S.O. 2007, c.8, s 60 (2) in that the licensee did not respond in writing within 10 days of receiving a concern or recommendation to the Family Council.

On April 14th, 2014 Inspector #541 reviewed the Family Council minutes for January, February and March 2014. On February 10th, 2014 a concern was brought forward to the licensee regarding a resident care issue and a response was not provided by the home until February 27th, 2014. On March 3rd, 2014 a concern was brought forward by the Family Council regarding missing window blinds and a written response was provided by the licensee on April 11th, 2014.

On April 14th, 2014 the president of the Family Council indicated during an interview with Inspector #541 that the Family Council does not receive a written response within 10 days when there is a concern or recommendation brought forward.

On April 14th, 2014 S106 reported to inspector #541 that a written response is not provided to the Family Council within 10 days of receiving concerns or recommendations. [s. 60. (2)]

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**Issued on this 16th day of April, 2014**

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

Paul Miller



**Ministry of Health and  
Long-Term Care**

**Order(s) of the Inspector**  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et  
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**Ordre(s) de l'inspecteur**  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

**Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité**

**Public Copy/Copie du public**

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**Name of Inspector (ID #) /  
Nom de l'inspecteur (No) :** PAUL MILLER (143), AMBER MOASE (541), BARBARA  
ROBINSON (572)

**Inspection No. /  
No de l'inspection :** 2014\_348143\_0005

**Log No. /  
Registre no:** O-000258-14

**Type of Inspection /  
Genre  
d'inspection:** Resident Quality Inspection

**Report Date(s) /  
Date(s) du Rapport :** Apr 16, 2014

**Licensee /  
Titulaire de permis :** CROWN RIDGE HEALTH CARE SERVICES INC  
106 CROWN STREET, TRENTON, ON, K8V-6R3

**LTC Home /  
Foyer de SLD :** CROWN RIDGE PLACE  
106 CROWN STREET, TRENTON, ON, K8V-6R3

**Name of Administrator /  
Nom de l'administratrice  
ou de l'administrateur :** GREG FREEMAN

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To CROWN RIDGE HEALTH CARE SERVICES INC, you are hereby required to  
comply with the following order(s) by the date(s) set out below:



**Ministry of Health and  
Long-Term Care**

**Order(s) of the Inspector**  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

**Ministère de la Santé et  
des Soins de longue durée**

**Ordre(s) de l'inspecteur**  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

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<b>Order # /</b> <b>Ordre no :</b> 001	<b>Order Type /</b> <b>Genre d'ordre :</b> Compliance Orders, s. 153. (1) (a)
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**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Order / Ordre :**

The licensee shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

**Grounds / Motifs :**





**Ministry of Health and  
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**Order(s) of the Inspector**  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
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**Ministère de la Santé et  
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Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

1. The Licensee has failed to comply with LTCHA, 2007, s.8(3) whereby a registered nurse who is both an employee of the licensee and a member of the regular staff of the home was not on duty and present in the home at all times, except as provided for in the regulations.

Crown Ridge Place is a 116 bed long term care home. During the Resident Quality Inspection, it was noted that the home has not ensured that at least one registered nurse is on duty and present in the home at all times.

Registered Nurse (RN) schedules were reviewed from March 10th to April 20th, 2014 with the Acting Director of Care (ADOC). For the period March 10th to April 6th, 2014 the home did not have a RN working on 6 night shifts for the hours from 2300 hours to 0700 hours. The ADOC stated the home used a Registered Practical Nurse to fill the vacant shifts.

The identified shifts not being covered by an RN are not the result of an emergency or a planned or extended leave of absence as outlined in the regulations. Therefore, the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff are not applicable as per Ontario Reg 79/10 s. 45 (2).

(143)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :** Aug 05, 2014



**Ministry of Health and  
Long-Term Care**

**Order(s) of the Inspector**  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

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de soins de longue durée*, L.O. 2007, chap. 8

## **REVIEW/APPEAL INFORMATION**

### **TAKE NOTICE:**

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
TORONTO, ON  
M5S-2B1  
Fax: 416-327-7603



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar  
151 Bloor Street West  
9th Floor  
Toronto, ON M5S 2T5

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance  
Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
TORONTO, ON  
M5S-2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).



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## **RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL**

### **PRENDRE AVIS**

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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de l'article 154 de la *Loi de 2007 sur les foyers  
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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto (Ontario) M5S 2T5

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la  
conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11e étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 16th day of April, 2014**

**Signature of Inspector /  
Signature de l'inspecteur :**

*Paul Miller*

**Name of Inspector /**

**Nom de l'inspecteur :** PAUL MILLER

**Service Area Office /**

**Bureau régional de services :** Ottawa Service Area Office