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

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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Apr 9, 2015	2015_362138_0009	O-001784-15	Resident Quality Inspection

Licensee/Titulaire de permis

~~SPECIALTY CARE OTTAWA INC.~~
~~400 Applewood Crescent Suite 110 VAUGHAN ON L4K 0G3~~

The Royal Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd
Suite 200 Markham ON
L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Granite Ridge
5501 Abbott Street East Stittsville ON K2S 2C5

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

PAULA MACDONALD (138), MEGAN MACPHAIL (551), SUSAN WENDT (546), WENDY PATTERSON (556)

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): March 30, 31, April 1, 2, 7, and 8, 2015.

Complaint O-001902-15 was also inspected as part of the RQI.

During the course of the inspection, the inspector(s) spoke with Residents, several Family Members, the Chair of the Residents' Council, the Chair of the Family Council, the Executive Director, the Director of Care, several Associate Directors of Care, the Registered Dietitian, several Personal Support Workers (PSWs), several Registered Practical Nurses (RPNs), several Registered Nurses (RNs), a Food Service Worker, a Housekeeping Aide, the Program Manager, the RAI Coordinator, a Restorative Care Staff, the Director of Environmental Services, and the Director of Resident & Family Services.

The inspectors also observed a meal service, reviewed resident health care records, toured resident and non residential areas, reviewed several of the home policies and procedures, observed a medication pass and medication rooms, reviewed the home's Facility Inspection Entrapment Sheet, reviewed Residents' Council Minutes, and reviewed an application for admission.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- 3 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff.

During the initial tour of the home's RQI inspection, on March 30, 2015, Inspector #546 observed the following:

On Garden House, the door to the linen room (room 168A) was unlatched and slightly ajar; the inspector was able to open the door by pulling on it. The room is equipped with a key lock; the door was unlocked at the time of observation. There was no staff in the vicinity of the linen storage room during this observation. Garden House is a secured resident home area where cognitively impaired residents live. It was noted that this room was not equipped with a resident-staff communication and response system (otherwise known as a call bell system). The room is used for the storage of extra linen.

On March 30, 2015, the following linen rooms were observed to be closed but unlocked, with no staff in the vicinity and with no resident-staff communication and response system in the rooms:
• Meadow House (room 171)
• Heritage House (room 244)
• Country House (room 344)

On March 30, 2015, the following linen room doors, although equipped with keypad locks,were observed to be open, with mechanical lift chargers inside and with no staff in the vicinity and no resident-staff communication and response system in the rooms:
• Harbour House (room 215)
• Cottage House (room 315)

On April 2, 2015, Inspector #546 observed linen room doors 168A, 171, 244 and 344 to be closed and unlocked, with no staff in the vicinity. The inspector observed linen room door 315, open with no staff in the vicinity of the linen room.

On April 2, 2015, RPN #100 confirmed that linen storage rooms were considered to be non-residential areas. PSW #101 also stated that the linen room door is supposed to be closed at all times as residents do not belong there. The Director of Care further confirmed that the linen rooms were non-residential areas. [s. 9. (1) 2.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During the course of the inspection, Inspector #556 observed 2 beds systems with bed rails that had a gap of approximately 6" at the top of the bed between the mattress and the headboard.

Associate Director of Care #113 inspected the beds in room 254 and 265 with Inspector #556 and stated that both beds were too long for the mattresses and there should be an extension put at the bottom of each mattress to make them fit the longer beds.

The Associate Director of Care #113 and Inspector #556 agreed that there was approximately a 6" space between the top of the mattress and the headboards of both beds, which according to Health Canada's document Adult Hospital Beds: Patient Entrapment Hazard, Side Rail Latching Reliability, and Other Hazards is referred to as zone 7. [s. 15. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to approve an applicant's admission to the home.

Applicant #045 was refused admission to the home as demonstrated by a letter from the home dated in July 2014, that sited a lack of nursing expertise necessary to meet the care requirements as the applicant was under the age of 65 with cognitive challenges, a current alcoholic, and not eligible to be assessed by the Royal Ottawa Hospital Geriatric Outreach Team.

Inspector #138 obtained a copy of Applicant #045's application assessment from the home and noted that the application was rejected in July 2014. The application assessment was reviewed by the inspector and it was noted that it did not outline any indication for the need of nursing expertise beyond that provided in long term care.

The inspector spoke with the Executive Director and the Associate Director of Care #111 regarding the refusal to approve Applicant #045's admission to the home. Neither were able to demonstrate that the home lacked the nursing expertise necessary to meet the care requirements for this applicant. The inspector also spoke with a Community Care Access Centre Case Worker #112 who confirmed that Applicant #045 was accepted on the waitlist by other long term care homes.
(O-001902-15) [s. 44. (7)]

Issued on this 9th day of April, 2015

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

Original report signed by the inspector.