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

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 # / Registre no	Type of Inspection / Genre d'inspection
Sep 7, 2016	2016_384161_0039	008235-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Granite Ridge Care Community
5501 Abbott Street East Stittsville ON K2S 2C5

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

KATHLEEN SMID (161), RUZICA SUBOTIC-HOWELL (548)

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): on-site August 29, 30, 31, 2016, September 1, 2, 2016.

During the course of the inspection, the inspector(s) spoke with residents, family members, Family Council Chair, Residents' Council Chair, Personal Support Workers, Food Service Workers, Housekeeping Aides, Maintenance staff, Office Manager, RAI Coordinator, Registered Practical Nurses, Registered Nurses, Director of Dietary Services, Director of Resident Programs, Interim Director of Care and the Executive Director.

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed the Admission Process, Infection Control and Quality Improvement & Required Programs checklists, residents' health care records, salient home policies and procedures, staff work routines, Resident and Family Council minutes. The inspector(s) observed resident rooms, resident common areas, the administration of medication and the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Pain
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

3 WN(s)
1 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

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

On August 29, 2016 Inspector #548 observed:

Room #313 Soiled Utility door on Country House is equipped with a key pad lock mechanism. The mechanism was engaged however, the door was slightly ajar. There was no staff present in the vicinity of the room.

Room #244 Linen Room on Heritage House, the door is equipped with a key pad lock mechanism. The mechanism was engaged however, the door was slightly ajar. There was no staff present in the vicinity of the room.

On the same day, the Inspector #548 observed on Harbour House the 2nd Floor Stairwell D door open when the push bar was pressed, into the stairwell. No alarm sounded when the inspector held the door open from 0945 to 0950. It was observed that two residents mobilized with walkers on their own accord in front of the stairwell door.

The stairwell door is equipped with a swipe pad for exiting and a magnetic lock. Adjacent to the stairwell door is a fire pull station (fire alarm) affixed with a lever. The pull station is protected from tampering with a clear plastic protector. The fire pull lever has two points of contact, one for the magnetic lock to the door and the other to engage the alarm. The lever is affixed with a set of screws on each side of the lever: the first set of screws at the top of the lever is for the magnetic lock and the second set of screws close to the base of the lever is for the alarm. When the fire alarm is fully engaged the magnetic lock releases the door for access (first point) and the alarm is activated (second point). It was observed on August 29, 2016 that when the Maintenance worker #101 tested the magnet, it was demagnetized. The fire alarm company was immediately contacted.

On August 30, 2016 during an interview the Interim Director of Care indicated that two weeks prior all of the fire alarms had been components had been checked, with no concerns raised. The Interim Director of Care indicated that the fire alarm company found that at the first point of the lever that the screws were loose causing the deactivation of the magnetic lock to the stairwell door.

The licensee has a history of unsecure and unlocked doors in non-residential areas of the home as indicated to the home's Resident Quality Inspection Log#: O-001784-15. [s. 9. (1)]

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 all doors leading to soiled utility rooms, linen rooms and stairwells are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee failed to comply with O. Reg. 79/10 s.8 (1)(b) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system to be complied with, in that the home failed to ensure compliance with the following policy.

As per O.Reg79/10, s. 114(2) The licensee shall ensure that the written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

On August 29, 2016 at 0910 hours Inspector #548 it was observed on resident unit a medication for an identified resident left on top of the medication cart, unattended. The RPN was not in the vicinity of the cart or within eyesight of the cart. The medication cart was in front of the doorway to the dining room where breakfast was being served. Several residents mobilized in wheelchairs on their own accord from the dining room in front of the cart.

On August 29, 2016 an identified indicated he/she receives his/her medication mid breakfast service.

At 0920 hours RPN #104 returned to the cart from the nursing station and verified that the medication for an identified resident would be administered to the resident after breakfast. RPN#104 indicated that the home's policy specifies that no medications are to be left unattended.

At 0930 hours on another resident unit Inspector #548 observed a bottle of Lactoluse on top of the medication cart, unattended and the medication cart unlocked. The RPN was not in the vicinity of the cart or in eyesight of the cart. The medication cart was in front of the unit's dining room. RPN #105 returned to the cart and concurred with her colleague that medications are not to be left unattended.

The home's policy titled: Medication Pass-Procedure, Index #: 04-02-20, Review date: June 23, 2014 specified that the medication cart is not to be left unattended at any time unless all medications are securely locked. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The Licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

An identified resident has several areas of compromised skin integrity. The resident is at risk for altered skin integrity related to immobility and chronic progressive disease. The resident has several co-morbidities.

On September 2, 2016 as described by the Associate Director of Care (ADOC) #113 the home's skin and wound program includes the documentation on the Skin and Wound Care Assessment form for the newly onset of wounds, the Skin Observation Note and the Skin Weekly Treatment Summary. The Skin-Observation Notes is for the documentation of the weekly assessment of signs and symptoms of infection, measurement of wound and evaluation of treatment. This is to be conducted on the first day of the resident's bath for the week and, the Skin Weekly Treatment summary is for registered staff to assess the compromised area which includes: the measurement of the

compromised area, staging, progression of the wound, discharge, the need of treatment, change of treatment, referrals if worsening and wound status. The ADOC indicated that compromised skin integrity skin tears and wounds require weekly assessment. The Interim Director of Care and RPN #112 confirmed this.

On September 2, 2016 during an interview the RPN #112 and the ADOC #113 both indicated that any wound that is stageable requires weekly wound assessments that would include: the measurement of the compromised area, staging, progression of the wound, the need of treatment, change of treatment, referrals if worsening and wound status. The ADOC #113 indicated that for those stageable wounds treated with a medicated paste the paste is not fully removed therefore the measurements of the wound are conducted if there is a change in the status of the wound such as discharge or signs and symptoms of infection.

The health record was reviewed.

On a specified date in January 2016 a progress note entry Skin-Weekly Treatment Summary indicated that the resident presented with a wound to a specified part of his/her body. Treatment was provided and the entry indicated that the care plan was not updated at the time.

On a specified date in April 2016 a progress note entry titled Skin-Observation Note reads: writer removed dressing from a specified part of the identified resident's body and noted areas to be red and sore to touch.

On a specified date in May 2016 a progress note entry titled Ski-Observation Note reads: Identified resident's wound: 3M spray BID.

On a subsequent date in May 2016 a progress note entry titled Ski-Observation Note indicated that the identified resident presented with two open areas to specified areas of their body. A skin assessment was on the home's Skin and Wound Care Assessment form and a progress note entry titled Skin-Observation Note described the wounds, interventions provided and referral to the Associate Director of Care #113, the home's Skin and Wound Specialist.

A progress note entry titled Skin-Weekly Treatment Summary on a specified date in May 2016 described the identified resident's wounds.

The Minimum Data Set assessment (MDS) completed on a date in July 2016 indicated that the identified resident had two wounds on specified areas of their body.

The next note entry Skin-Weekly Treatment Summary for three specified dates in June 2016, two specified dates in July 2016 and four specified dates in August 2016 indicated that the identified resident has two wounds on specified areas of their body.

During an interview the ADOC#113 she indicated that the description of the wounds and their status were not completed as required by the registered nursing staff. The ADOC provided to the inspector a document titled : Wound and Skin Program 2016. The document is a report on the status of wounds by resident. It indicated that one of the wounds of the identified resident was closed in May and the other wound was healed in September 2016.

In this instance, there was conflicting information presented to the inspector #548 at the time of the resident quality inspection. However, the expectation of the home as specified by the ADOC #113 Skin Care Coordinator indicated that all altered skin integrity requires a an assessment on a weekly basis. [s. 50. (2) (b) (iv)]

Issued on this 7th day of September, 2016

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

Original report signed by the inspector.