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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 14, 2017	2017_593573_0025	013376-17	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

ANANDRAJ NATARAJAN (573), KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 19, 20, 23, 24, 25 and 26, 2017.

The following Critical Incident inspections were conducted concurrently during this Resident Quality Inspection: Critical Incident Logs #010727 -17, #014399 -17, and #016728 -17 related to incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. Log #019941 -17 related to a resident to resident alleged sexual abuse.

During the course of the inspection, the inspector(s) spoke with residents, family members, Family Council President, Residents' Council President, Personal Support Workers (PSW), Restorative Care Staff, Registered Practical Nurses (RPN), Registered Nurses (RN), Dietitian, Physiotherapist, RAI Coordinator, Associate Director of Care, Director of Care and the Executive Director.

During the course of the inspection, the inspector(s) observed residential and non-residential areas of the home, observed a medication pass including medication room, observed recreation activities, observed staff to residents interaction and resident to resident interactions. In addition, the inspectors reviewed the home's relevant policies and required programs, reviewed minutes for Residents' Council and reviewed Resident Health Care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #24's written plan of care set out the planned care for the resident and provided clear direction to staff regarding the use of specified shower chair for the resident's shower.

On an identified date Critical Incident Report (CIR) was submitted to the Director, regarding an incident for which resident #024 was sent to the hospital and resulted in a significant change in resident's health status. The CIR report indicated that resident's specific body part was injured during the transfer.

Inspector #573 reviewed resident #024's progress note documentation by the home's Nurse Practitioner on an identified date, indicated that resident #024 was found on a shower chair with an injury to a specific body part. Further, the documentation indicated that the resident was transferred to hospital for further management.

On October 23, 2017, Inspector #573 spoke with PSW #112, who indicated that on an identified date, she and PSW #113 transferred resident #024 from wheelchair to a regular shower chair. PSW #112 indicated that during resident #024's shower, she observed resident was getting more nervous, agitated and was scooting forward in the shower chair. The PSW staff indicated that since resident was agitated, resident's shower was getting difficult and staff feared that resident might fall from the sling/ shower chair. So they decided to stop the shower and rang the call bell for the third staff assistance. PSW #112 indicated that PSW #119 came to assist with resident #024 transfer. Further, she indicated during the transfer resident #024's specific body part was injured as it came in contact with the shower chair. The PSW indicated that the RN was

notified immediately.

On October 24, 2017, Inspector #573 spoke with physiotherapist who indicated that on an identified date, after the incident, she assessed resident #024 for appropriate showering techniques and devices. The PT indicated that regular PSW staff on the unit informed the PT that resident #024 used to have shower on a specified shower chair for comfort and safety. Further, the PT indicated that the specified shower chair was recommended for resident's showers.

On October 24, 2017, Inspector spoke with RN #114, who indicated that on an identified date, she and the home's Nurse Practitioner assessed resident #024's injured body part. RN #114 indicated to the inspector that for resident #024's shower, PSW staff members could have used the specified shower chair instead of the regular shower chair.

A review of resident #024's written plan of care at the time of incident for transfers indicated that the resident required a mechanical lift with two staff members for all transfers. Further, it indicated that resident was unable to participate and is totally dependent for the entire process for transfers. Resident #024 written plan of care does not have any information or clear direction for staff regarding the use of a specified shower chair for the resident.

On October 26, 2017, Inspector #573 spoke with the Director of Care (DOC) who indicated that they conducted an internal investigation regarding incident on an identified date. The DOC stated that during the investigation, factors contributing to the incident were discussed with the PSW staff members and actions were taken to prevent recurrence. Further, the DOC indicated that prior to the incident the resident #024's written plan of care did not indicate nor provided any directions for staff regarding the use of specified shower chair for the resident. (Log #010727-17) [s. 6. (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 resident's written plan of care set out the planned care for the resident and provide clear direction to staff regarding the use of specified seating devices or products based on the resident's condition when assisting with a resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall clearly set out what constitutes physical abuse.

On October 24, 2017 Inspector #161 asked for and received from the home's Executive Director (ED), the licensee's most recent policy to promote zero tolerance of abuse and neglect of residents. The ED provided Inspector #161 with a licensee policy titled "Prevention of Abuse and Neglect of a Resident - #V11-G-10.00" revision date January 2015 with the following attachments: "Prevention of Abuse - Definitions of Abuse – V11-G-10.00(a)" revision date January 2015; "Prevention of Abuse - Nursing Checklist for Investigating Alleged Abuse – V11-G-10.00(b)" revision date January 2015; and "Prevention of Abuse - Investigation Template– V11-G-10.00(c)" revision date January 2015.

As per O.Reg.79/10, s.2(1), physical abuse is defined as (a) the use of physical force by anyone other than a resident that causes physical injury or pain, (b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident.

On October 25, 2017 Inspector #161 reviewed the licensee's policy titled "Prevention of Abuse - Definitions of Abuse – V11-G-10.00(a)" revision date January 2015. The licensee's definition of physical abuse stated, in part, "(a) any action of physical force or restraint by anyone who understands and appreciates the consequences of their own actions that is contrary to a resident's health, safety or well being and that causes pain or may cause pain or physical harm to a resident and; (b) over medication, withholding medication or medicating of a resident when it is not medically necessary to do so The licensee's policy titled "Prevention of Abuse - Definitions of Abuse – V11-G-10.00(a)" revision date January 2015 (a) limited the definition of physical abuse by restricting it to anyone who understands and appreciates the consequences of their actions (c) did not include causing physical injury, nor did this policy include an inappropriate purpose for administering or withholding a drug. (Log #019941-17) [s. 20. (2)]

Issued on this 14th day of November, 2017

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

Original report signed by the inspector.