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 prévue 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 28, 2018	2018_683126_0021	026188-17, 001957-18, 016408-18, 025612-18	Complaint

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 16, 17, 18, 19, 22, 23, 24, 25, 26, 2018

During the course of this inspection the following logs were inspected:
Log #016408-18, 001957-18, 025612-18 and 026188-17 related to resident's care and services

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), two Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), the Quality Improvement Nurse and the resident.

During the course of the inspection, the inspector reviewed resident health care records, licensee's relevant policies and procedures.
In addition the inspector observed the provision of care and services to residents and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. Related to Log # 001957-18
The licensee has failed to ensure that the care set out in the plan of care is provided to

the resident as specified in the plan.

Resident #001 was admitted to the home with several diagnoses. On a specific date, resident #001's Substitute Decision Maker (SDM) indicated that resident #001 blood monitoring had an abnormal value and the nurse did not notify the physician at that time when it was expected that the physician be contacted. Later that afternoon, the physician on call was notified of the abnormal value result and new orders were received.

In reviewing resident #001 health care record, the following was noted:

On a specific date, there was a written order to contact the physician if resident's #001's blood monitoring was abnormal.

Medication Administration Records (MAR) were reviewed for three specific months and the following was noted: Blood monitoring was to be done in the morning and if the result was abnormal the physician should be contacted.

On a specific date, there was a written order to increase a medication and to modify the frequency of the blood monitoring. The Assistant Director of Care (ADOC) #117 who wrote the new order for Physician #118, indicated that the blood monitoring was to call the physician if it there was an abnormal value and that this order remained on the MAR as this directive was not discontinued.

On a specific date, there was a written order to increase a medication if blood monitoring indicated an abnormal value, to administer the medication and then notify the family. The ADOC #102 who wrote the order for Physician #118, indicated that the order meant that if the blood monitoring was indicating a specific abnormal value to call the Physician to get a new order for the medication. ADOC #102 indicated that the order was confusing.

Resident #001's quarterlies "Physician Medication Review" were reviewed for several months and it was noted that on each quarterly, Physician #118 signed to renew the monitoring of the blood and if value became abnormal to contact the physician. This physician order was not transcribed on the MAR by the pharmacy.

Discussion held with Director of Care (DOC) # 101 indicated that at one time, the direction to call the physician if blood monitoring was abnormal was written under special instruction in the resident electronic file.

Discussion held with Registered Nurse (RN) # 107 indicated that they could not recall specifically were it was written to call the physician if the blood monitoring was abnormal.

The licensee has failed to ensure that clear direction related to the resident's blood monitoring was clearly set out in the plan of care and the care was provided to the resident as specified in the plan of care on a specific day. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1.The licensee has failed to ensure that all staff have received training in the following areas before performing their responsibilities in the areas mentioned below:
1. The Residents' Bill of Rights, 2. The home's mission statement, 3. The home's policy to promote zero tolerance of abuse and neglect of residents, 4. The duty to make mandatory reports under section 24, 5. The whistle-blower protections under section 26, 6. The home's policy to minimize the restraining of residents, 7. Fire prevention and safety, 8. Emergency and evacuation procedures, 9. Infection prevention and control, 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities, 11. Any other areas provided for in the regulations.

Resident #001's Substitute Decision Maker (SDM) indicated to Inspector #126 that Registered Practical Nurse #104 asked resident #001's visitor about the resident's condition.

The (SDM) indicated concerns about the orientation and training programs of new RPN #104 and indicated that RPN #104 did not received proper orientation/training.

Discussion held with the Director of Care #101 who indicated that the orientation program for nurses consist of: one day in class training on specific policies and procedures, one off unit training with a nurse to complete the "Passport Checklist", one shadowing on day, evening and nigh shift on the unit and may have extra training shift if required. DOC #101 indicated that RPN #104 completed two shadowing shift on day and evening.

Discussion held with RPN #103, who shadowed RPN #104 on the off unit on a specific date on the day shift and on the unit on a specific day shift. RPN #103 indicated that RPN #104 completed the lunch medication pass and did not present with any difficulty. RPN #104 did not required extra training.

Discussion held with RPN #105, who shadowed RPN #104 on a specific evening shift. RPN #105 indicated that RPN #104 observed most of the evening shift and did not do any medication pass. RPN #104 did not required extra training.

Discussion held with the Quality Improvement Nurse (QIN) #106, who indicated that they are in charge of Day 1 orientation in class to complete the "General Orientation Checklist" with the new hire. QIN #106 indicated to Inspector #126 that the "Relias Module" does not include the specific legislation for the province of Ontario. QIN #106 indicated that extra training about the legislative requirements was not given to the new hire.

Discussion held with the Quality Improvement Nurse (QIN) #106, who indicated that they are in charge of Day 1 orientation in class to complete the "General Orientation Checklist" with the new hire. QIN #106 indicated to Inspector #126 that the "Relias Module" does not include the specific legislation for the province of Ontario. QIN #106 indicated that extra training about the legislative requirements was not given to the new hire.

Inspector #126 reviewed the content of the home's day 1, orientation session. It was

noted that the education provided to new staff did not include the following areas: the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, the whistle-blower protections under section 26 and the home's policy to minimize the restraining of residents. The "Relias Module" included "Abuse and Neglect for Canada, Resident Rights for Canada, Siena Restraint Minimization policy" but does not included the specific Ontario legislative requirements. RPN #104 completed the orientation program as planned.

The licensee has failed to ensure that all staff received the training as per the legislative requirements related to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, the whistle-blower protections under section 26 and the home's policy to minimize the restraining of residents. [s. 76. (2)]

2. The licensee has failed to ensure that all staff have received retraining annually relating to the following: 1. The Residents' Bill of Rights, 2. The home's mission statement, 3. The home's policy to promote zero tolerance of abuse and neglect of residents, 4. The duty to make mandatory reports under section 24, 5. The whistle-blower protections under section 26, 6. The home's policy to minimize the restraining of residents, 7. Fire prevention and safety, 8. Emergency and evacuation procedures, 9. Infection prevention and control.

Discussion held with DOC #101 who indicated that mandatory annual education is required for staff and that by October 31, 2018 all staff should have completed the annual education. DOC #101indicated that the annual education was done via "Relias online Modules" and provided Inspector #126 with the list of the training modules. This list included: "Abuse and Neglect for Canada, Customer Service for Canada, Fire Safety: The Basics for Canada, Hazard Communication MDS and SDS for Canada, Infection Control and Prevention for Canada, Personal Protective Equipment for Canada, Preventive Workplace Violence for Canada, Resident Rights for Canada and Siderails- A hidden Danger for Canada". Inspector #126 reviewed the content of the presentation on abuse, restraint and it was noted that the module does not include the specific Ontario Legislative requirements.

The licensee has failed to ensure that the annual retraining include the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, the whistle-blower protection under section 26 and the home's

policy to minimize the restraining of residents. [s. 76. (4)]

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 staff have received training in the following areas before performing their responsibilities in the areas mentioned below: 1. The Residents' Bill of Rights, 2. The home's mission statement, 3. The home's policy to promote zero tolerance of abuse and neglect of residents, 4. The duty to make mandatory reports under section 24, 5. The whistle-blower protections under section 26, 6. The home's policy to minimize the restraining of residents, 7. Fire prevention and safety, 8. Emergency and evacuation procedures, 9. Infection prevention and control, 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities, 11. Any other areas provided for in the regulations., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

The licensee has failed to ensure that staff apply the physical device in accordance with any manufacturer's instructions.

Resident #001 requires a front seat belt restraint at all time, when sitting up in the wheelchair (w/c). Resident #001 has a pelvic support belt that requires to be "worn tightly

fitted across the lower pelvis or thighs at all times"

Resident #001's Substitute Decision Maker (SDM) indicated to Inspector #126 that resident #001's seat belt was not applied correctly and was twisted on one side, on a specific evening. The SDM stated that the belt was reapplied correctly and the staff were notified.

During an interview with Registered Practical Nurse (RPN) #111, indicated to Inspector #126 that on a specific date in the in the morning, resident #001's SDM came up and informed him/her that resident's seat belt was not applied correctly and was twisted at the waist. RPN #111 indicated that Personal Support Worker (PSW) #114 and #115 provided care to resident #001 that morning.

On a specific date, Inspector #126 was informed by resident #001's SDM that the seat belt was twisted on one side of the belt two days later. The SDM indicated that RPN #113 and Registered Nurse (RN) #116 were informed and had seen the seat belt twisted. RN #113 informed Director of Care (DOC) #101 that same evening. DOC #101was still in the home that evening and went to resident #001's unit, talked to the SDM and to the nursing staff about the correct application of the seat belt. PSW #112 informed the DOC that they had attached the seat belt and that it was the second time that the belt was found twisted.

Discussion held with the DOC who indicated that a plan for education was prepared and that education was going to be done on resident #001's unit to ensure the seat belt is applied correctly. An email was going to be sent to the registered nursing staff this day.

Discussion held with PSW #112 who indicated that when the belt was applied, it appeared to have been applied correctly when observed from the front. PSW #112 indicated that they had not checked the belt from the back support of the chair to the front. PSW #112 also indicated that the side foam arm rest limits the visibility of the belt at the back. PSW #112 indicated that resident #001's SDM informed him/her that the belt was twisted on two specific evening shifts.

Discussion held with RPN #113, indicated that resident #001's SDM informed him/her that the seat belt was not applied correctly. RPN #113 observed resident #001 with a twisted belt, at the back on the right side of the resident.

Resident #001 seat belt was not applied in accordance with any manufacturer's

instructions on three different occasions. [s. 110. (1) 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 staff apply the physical device in accordance with any manufacturer's instructions., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee has failed to comply with the restraint policy.

In accordance with s.29. (1), every licensee of a long-term care home, (a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations.

The licensee Restraint implementation Protocols, Policy #: VII-E-10.00, current revision date January 2015, under Procedure, requires the Registered Nurse/ Registered Practical Nurse to:
"7) Review and document every 8 hours on the restraint monitoring record to evaluate the need for continued restraint use, effectiveness of restraint, and that it continues to be required".

Inspector #126 reviewed a monthly "Appendix II-Restraint Monitoring Record" for resident #001. It was noted that on two evening shifts, it was not signed by the nurse.

Discussion held with Registered Practical Nurse (RPN) #110, who worked on one of the evenings, indicated that resident #001 was observed and assessed as per policy during the evening but forgot to sign the record at the end of the shift.

Discussion held with RPN #111, who worked on the day shift of that specific day, indicated that resident #001 was observed and assessed on the day shift but did not sign the monitoring record at the end of the shift.

The Monitoring Restraint Record for a specific period was not signed on two occasions as per the licensee restraint policy requirement to be signed on every shift. [s. 29. (1) (b)]

Issued on this 28th day of December, 2018

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

Original report signed by the inspector.