Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 24, 2020	2020_597655_0001	016311-20	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

MICHELLE EDWARDS (655)

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): August 14, August 18 - 21, August 25- 28, August 31, 2020; and, Septemeber 1, 2020. The inspection was conducted off-site.

The following intakes were completed during this inspection:
- Log #016311-20 related to a request for readmission.

During the course of the inspection, the inspector(s) spoke with a family member, personal support workers (PSWs), registered practical nurses (RPNs), the Associate Director of Care (ADOC), the Resident Relations Coordinator (RRC), the Executive Director, an Ottawa Public Health Inspector, an Ottawa Public Health Nurse, a member of the Ottawa Public Health Infection Prevention and Control (IPAC) team, a Care Coordinator with the Champlain Local Health Integration Network (LHIN), and the Manager of Home and Community Care, Champlain LHIN.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

During the course of this inspection, Non-Compliances were issued.
- **1 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	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 O.Reg 79/10, s. 140. Every licensee of a long-term care home shall ensure that each medical absence, psychiatric absence, casual absence and vacation absence of a resident of the home is recorded. O. Reg. 79/10, s. 140.

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's absence from the long-term care home was recorded.

In a resident's health care record, it was indicated that the resident was discharged from the long-term care home. There was no other information found in the resident's health care record related to a request made by the resident or the substitute decision maker for the discharge.

According to Ontario Regulation (O. Reg) 79/10, s. 147.1 (1), during a pandemic, a licensee of a long-term care home shall discharge a resident if the resident or the resident’s substitute decision-maker (SDM) provides a written request to be discharged because of the pandemic.

The SDM indicated that they were not required to submit a written request for the resident's discharge. The Resident Relations Coordinator (RRC) confirmed that they had been approached by the resident’s SDM regarding a request to discharge this resident and that the request was made verbally, not in writing. The resident's absence from the long-term care home was not recorded in accordance with s. 147.1 (1) of O. Reg. 79/10.

Sources: Resident health care record, interview with family member, RRC, and others. [s. 140.]

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Issued on this 5th day of November, 2020

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

Original report signed by the inspector.