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, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 3, 2014	2014_128138_0008	O-000054-14	Resident Quality Inspection

Licensee/Titulaire de permis The Royale Development GP Corporation as general partner of The Royale Development LP

PM ~~SPECIALTY CARE OTTAWA INC.~~
~~400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3~~ 302 Town Centre, Suite 200 Markham ON L3R 0E8

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

PM ~~SPECIALTY CARE~~ GRANITE RIDGE
5501 Abbott Street East, Stittsville, ON, K2S-2C5

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

PAULA MACDONALD (138), COLETTE ASSELIN (134), MEGAN MACPHAIL (551), 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): February 19, 20, 21, 24, 25, 26, 27, and 28, 2014

Critical Incident Inspection O-000027-14 was also completed at the time of the RQI.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), the Director of Programs (and Admissions), a RAI Coordinator, the Staffing Clerk, several registered nurses (RN), several registered practical nurses (RPN), several personal support workers (PSW), the Director of Dietary Services, food service workers, the Registered Dietitian, the Office Manager, an office assistant, the Recreation Therapist, the Assistant Director of Care (ADOC), several Resident Care Coordinators, the Environmental Service Manager, a maintenance staff member, housekeeping aides, laundry aides, physiotherapy aides, Chair of Residents' Council, the Family Council Treasurer, residents, family members, and a private care giver.

During the course of the inspection, the inspector(s) reviewed residents' health care records, reviewed several of the homes' policies and procedures, reviewed a Critical Incident Report, toured resident rooms, toured resident common and non common areas, reviewed the admission package, reviewed Residents' Council and Family Council minutes, observed a medication pass, observed lunch meal service and several snack passes, and observed the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA, 2007 S.O. 2007, c. 8, s. 3 (11) iv, in that residents' personal information within the meaning of the Personal Health Information Protection Act, 2004, was not kept confidential in accordance with that Act.

On February 21, 25 and 28, 2014, LTCH Inspector #134 observed several empty medication strip packets, providing information regarding the residents' name, list of medication and time of administration, and they were found in the regular garbage bags, attached to the med cart on Lake, Country and Meadow units.

Three staff member working on different units were interviewed and indicated that throwing the empty medication packets in the regular garbage bag was their normal practice.

As such, the residents' rights to have his/her personal information kept confidential, was not respected and promoted. [s. 3. (1) 11. iv.]

WN #2: 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).

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. The licensee failed to comply with the LTCHA, 2007 S.O 2007, c. 8, s. 6 (1) (c) in that a resident's care plan does not provide clear direction to staff as it relates to providing safe mouth care.

A resident with his/her own teeth has mouth pain, and according to the resident's family member, this mouth pain is due to the loss of tooth enamel.

A staff member was interviewed by LTCH Inspector #134 and reported that the resident will bite on the toothbrush or toothette when mouth care is provided. The staff member indicated the resident's gums bleed during mouth care and show signs of mouth pain manifested by agitation. The staff member indicated that since the resident bites hard on the toothette or tooth brush staff will go along the contour of the resident's mouth without placing the toothbrush directly in centre of the mouth to prevent injury. The staff member indicated that the resident is strong and could cut the toothette stick with his/her teeth.

Two staff members indicated that staff are to brush the resident's teeth using a manual toothbrush and use small amounts of Sensodyne toothpaste. The staff members indicated toothettes are also used but care needs to be taken as the resident will bite and could break the toothette off in his/her mouth.

The resident's washroom was inspected and there is an electric toothbrush which is

plugged in but the staff members indicated they did not use it to brush the resident's teeth.

The care plan was reviewed and there is no clear direction to staff on how to provide safe mouth care to the resident. There is one entry under oral hygiene that specifies "one staff member to provide total assistance with mouth care". [s. 6. (1) (c)]

2. The licensee failed to comply with the LTCHA, 2007 S.O. 2007 c. 8, s. 6 (7) whereby care was not provided to a resident as per the care set out in the plan as it relates to fall prevention.

A resident fell on a date in January 2014, and sustained several injuries. The resident was sent to hospital for treatment and assessment the same evening as the fall.

According to a staff member, the resident was able to walk independently prior to the fall. Since the fall, the staff member indicated that the resident is more confused, does not follow directions as well and is incoherent and unable to walk or transfer independently.

On February 26, 2014, at 14:10 LTCH Inspector #134 observed the resident in his/her room. The resident was resting in bed at the time with shoes on, the wheelchair by the bed, both rails were down, the call bell was not accessible and the fall out mat was resting against the wall opposite the bed.

Another staff member was interviewed by LTCH Inspector #134 at 14:15 on February 26, 2014 and stated that both rails were down when she went in that morning to care for the resident. The staff member stated that she automatically thought that the resident was to have the bedrails down when in bed in the afternoon. She indicated that if a resident is at risk of falls it is usually preferable to place the chair out of sight to prevent the residents from trying to get up on their own.

A staff member, who was assigned to the resident, was interviewed and indicated that the resident requires one rail up, with the fall out mat by the bed, the call bell is to be accessible. The staff member indicated she was concerned that the resident would try to get up on his/her own and placed the wheelchair close to the bed in case an attempt was made to get out of bed.

The resident's care plan was reviewed and there is an entry under high risk of falls

characterized by history of falls/injury, multiple risks related to impaired balance, poor coordination, unsteady gait, pain, poor judgment. The interventions specified are as follows: blue mat to be used when in bed, reinforce need to call for assistance, call bell within reach when in bed, to wear proper non slip footwear, one bed rail up when in bed.

As such, the care set out in the plan was not provided to the resident as specified in the written plan of care. [s. 6. (7)]

WN #3: 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 :

1. The licensee failed to comply with O. Reg 79/10, s. 8. (1) (b) in that the licensee failed to ensure that any policy required to be put in place according to the LTCHA 2007 and O.Reg 79/10 is complied with.

In accordance with LTCHA 2007, s 8., s. 11., O. Reg 79/10, s. 8. (1) (b), s. 30. (1) 1., s. 48. (1) 2., and s. 50 (2) (b) (iii), the licensee of the home must ensure that there is an organized program for nutrition care, nursing care, as well as a multi disciplinary skin and wound care program. The licensee must also ensure that there are policies in place for these programs, that these policies are implemented and that these policies are complied with.

LTCH Inspector #138 reviewed the home's policy titled Skin and Wound Care Management Protocol VII-G-20.10 that was dated September 2013 from the Resident Care Manual. The policy states that the registered staff will refer a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds

to the registered dietitian for assessment.

The LTCH Inspector #138 reviewed the health care record for a resident who was triggered from Stage 1 of the RQI due to a worsening pressure ulcer. LTCH Inspector #138 noted in the progress notes that a pressure ulcer with an open area began in November 2013 and closed in January 2014. It was also noted that a second pressure ulcer with an open area started in February 2014 and remains ongoing at the time of the inspection. There was no documentation in the resident's health care record that demonstrated that the resident had been assessed related to altered skin integrity by the home's registered dietitian as required by O. Reg 79/10 section 50 (2) (b) (iii).

LTCH Inspector #138 spoke with a registered staff on the resident's unit regarding the assessment of residents exhibiting pressure ulcers by the home's registered dietitian. The staff member stated that residents with pressure ulcers are only referred to the home's dietitian if the resident is not eating or drinking well. The staff member further stated that that particular resident is doing well nutritionally and so no referral has been made to the registered dietitian for assessment.

LTCH Inspector #138 spoke with the home's registered dietitian on February 25, 2014. The Registered Dietitian stated that she had not received a referral regarding the resident's current pressure ulcer and further stated she does not always receive a referral for residents with altered skin integrity.

LTCH Inspector #138 also spoke with the Director of Dietary Services who stated that a referral to the registered dietitian was not sent for that specific resident for the pressure ulcer with an open area that began in November 2013. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to comply with O. Reg 79/10 section 8. (1) (b), whereby the fall prevention policy # VII-G-60.00 was not complied with as it relates to head injury routine.

A resident fell on a date in January 2014 resulting in injuries including a head injury. The resident was sent to the hospital for treatment and assessment and came back to the home 23 hours later. The HIR was to be resumed as per policy. The CT scan revealed injuries including injuries to the head.

The Licensee's Fall Prevention Policy # VII-G60.00 was reviewed. There is an entry under section Post Fall Assessment (page 2 bullet 5 and 9) specifying to monitor Head Injury Routine (HIR) for 48 hours post fall for signs of neurological changes and to document assessments and all interventions taken on the progress notes and vital sign recording on VII-G-10.22 (a) Head Injury Routine Monitoring Record and place in the resident's chart upon completion.

The progress notes, vital sign records off Point Click Care, physician's orders were reviewed and there is no indication that the HIR was monitored, as per policy requirement, for 48 hours and no indication that the physician discontinued the HIR.

The Head Injury Monitoring Record was not found in the chart.

As such, the Head Injury Policy # VII-G-10.22 was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee failed to comply with O. Reg 79/10, s. 8. (1) (b), in that drugs that are to be destroyed and disposed of were not stored safely and securely.

The licensee's policy # 02-06-20 re Disposal of Discontinued/Expired Medication, was reviewed. There is an entry under bullet #2 specifying that drugs that are to be destroyed of are to be stored safely and securely.

On February 21, 2014 at 11:37, LTCH Inspector #134, inspected the medication room on Garden. A metal safe with two drawers was used to store discontinued narcotics and controlled drugs, which was double locked at the time.

When LTCH Inspector #134 opened the upper drawer of the safe it was observed that one card of Tylenol #3 was sitting on top of the drawer. A staff member indicated the lower section of the safe was full with discontinued narcotic cards, preventing more narcotic and controlled drugs to slide into the storage area of the safe. The LTCH Inspector was able to reach in the metal storage bin and pull out 10 discontinued narcotic cards with ease.

On February 21 and February 26, 2014, LTCH Inspector #134 inspected the medication room and observed that several stericycle bins containing discontinued and overflow medications where not sealed securely with appropriate lids on Country, Garden and Lake units.

As such, the licensee's policy was not complied with as it relates [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, 2007 S.O 2007, c. 8, s. 15 (2) (c), whereby the home and its furnishing are not in a good state of repair.

During the inspection LTCH Inspectors #556 and #134 toured the units and observed the following on Orchard:

Four of the chairs in sitting area by the shower room are stained and all have scraped wooden legs and arms.
Several broken tiles in the shower room and damage to the paint on the inside of the door.
The baseboard at the entrance to the dining room is coming off, the walls in the dining room are damaged and the paint is scraped and chipped.
Four dining room chairs are stained and legs/arms are scraped.
The restorative care room has stained ceiling tiles, due to ice build up on roof.
The activity room has stained ceiling tiles, damage to the paint, and scraped finish on the wooden legs of the chairs.
There is yellowish stain on the ceiling tile and wrinkling of paint high up on the wall outside room #348.
There is yellow staining on the ceiling tile by the exit sign by the 3rd floor stairwell F, as well as stains on the carpet at the end of the hall by stairwell F.
There is damage to the wall by the fire extinguisher opposite the door at the Stairwell

F.
Small crack in the drywall above room #345.
Black matter noted on ceiling tiles around ceiling fan outside room #360, and the same around the ceiling fan outside room #359.
Broken ceiling tile across from room #358.

The following environmental observations were observed on Country:

The tub room door scuffed, staining on paint outside room doors around hand sanitizer units, scuffed and chipped paint on linen room door #344.
Scuffing on lower walls below the light blue bumper, chipped paint outside room #316.

Damaged surface in tub on 3rd floor Country, surface is chipped.
Paint on the inside of the tubroom door is scrapped and chipped.
Damaged paint, scuffed and chipped on the inside and outside of the shower room door on unit.
Scuffed finish on lounge chair at the end of the hall outside stairwell B.
Small carpet stain outside room #307.
Chipped paint in the hall between rooms #305 and #306.
Some staining and a small area of carpet damage outside dining room.
The back wall of the dining room is scraped and damaged.
Paint on the dining room doors is chipped and scuffed.
Lower walls in small dining room alcove are badly damaged.
Four of the light blue dining room chairs are stained.
In the Fireplace Lounge, some areas of damage to paint and drywall, a very dirty black lounge chair, one stained light blue dining room chair.
Den has a piano that is scuffed and worn looking with missing pieces of laminate trim, and 2 lounge chairs with the finish on wooden parts of the chair worn, scuffed, and chipped.
Activity room has some stained area of carpets, 2 stained light blue dining room chairs, one with badly scuffed legs, 3 lounge chairs with wooden legs and arms, and the finish on the wooded areas on all 3 chairs is scuffed and chipped, there is a table with the laminate trim missing on the end of the table by the window, the lower wall under the bulletin board is scuffed and dirty. [s. 15. (2) (c)]

Issued on this 3rd day of March, 2014

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

PAULA MACDONALD WENDY PATTERSON

Megan MacPhail, RD