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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Jan 14, 2016	2015_384161_0024	035173-15	Critical Incident System

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 18, 21, 22, 2015.

During the course of the inspection, the inspector(s) spoke with the Office Manager, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Assistant Director of Care (ADOC), Director of Care, Executive Director and an identified Resident's Attending Physician.

During the course of the inspection, the inspector(s) reviewed a Critical Incident Report for an identified date in December 2015, Resident #001's health care record, a Nursing Daily Roster Report and the home's Pain and Symptom Management Policy and Procedure V11-G-30.10 (dated January 2015).

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Pain

During the course of this inspection, Non-Compliances were issued.
3 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	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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that the Resident is reassessed and the plan of care reviewed and revised at any time when the Resident's care needs change or care set out in the plan of care is no longer necessary.

On a specified date in November 2015 Resident #001 developed a sudden onset of lower back pain. An x-ray revealed that the Resident had sustained a compression fracture. From this date in November 2015 until the Resident's death on an identified date in December 2015, Resident #001 continued to experience intermittent severe pain which was treated with progressive changes in analgesics as per the attending physician's orders. On December 21, 2015 Inspector #161 asked for and received from the DOC, Resident #001's most recent plan of care dated November 2015. A review of this plan of care indicated that the Resident's lower back pain, caused by a compression fracture, had not been identified nor the associated interventions.

On an identified date in December 2015 Resident #001 started to complain about difficulty on urination. The Resident was catheterized and started on a medication to treat this condition. The Resident continued to intermittently complain about difficulty on urination and required monitoring of her/his bladder function. A review of Resident #001's most recent plan of care dated November 2015 indicated that the Resident's difficulty on urination had not been identified nor the associated interventions.

On December 21, 2015 the Director of Care confirmed that Resident #001's lower back pain and difficulty on urination, including the associated interventions, should have been indicated on the Resident's plan of care.

As such, the licensee failed to ensure that Resident #001's plan of care was reviewed and revised when the Resident's care needs changed as of an identified date in November 2015 and an identified date in December 2015. [s. 6. (10) (b)]

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 when a Resident develops pain that is treated with non pharmaceutical approaches and/or with analgesics, that the Resident's plan of care is reviewed and revised when the Resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when a Resident's pain is not relieved by initial interventions, the Resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

On an identified date in November 2015 Resident #001 developed a sudden onset of lower back pain. An x-ray revealed that the Resident had sustained a compression fracture. From the identified date in November 2015 until the Resident's death on an identified date in December 2015, Resident #001 continued to experience intermittent severe pain which was treated with progressive changes in analgesics as per the attending physician's orders.

On December 21, 2015 Inspector #161 asked for and received from the DOC the home's Pain and Symptom Management Policy and Procedure #V11-G-30.10 (dated January 2015). A review of this policy/procedure indicated that Registered Nursing Staff were required to initiate the home's 24-hour Pain and Symptom Monitoring tool when (1) there was a change in a Resident's condition with pain onset and (2) weekly thereafter.

On December 21, 2015 Inspector #161 and the DOC reviewed Resident #001's health care record from the beginning of November 2015 until the Resident's death on an identified date in December 2015. There was no 24-hour Pain and Symptom Monitoring tool used when Resident #001's condition changed with the sudden onset of lower back pain, nor was the tool used weekly thereafter. On December 21, 2015 the DOC confirmed that the home's 24-hour Pain and Symptom Monitoring tool had not been used.

As such, the licensee failed to ensure that when Resident #001's pain was not relieved by initial interventions, that the Resident was assessed using the home's clinically appropriate assessment instrument specifically designed for this purpose and weekly thereafter as per the home's Pain and Symptom Management Policy and Procedure #V11-G-30.10 (dated January 2015). [s. 52. (2)]

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 when a Resident's pain is not relieved by initial interventions, that the Resident is assessed using the home's clinically appropriate assessment tool designed for this purpose and weekly thereafter as per the home's Pain and Symptom Management Policy and Procedure, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On an identified date in December 2015 Resident #001 was prescribed an analgesic to be administered every 8 hours as scheduled; an antiemetic to be administered twice daily as scheduled; and a narcotic analgesic to be administered every six hours as scheduled.

On an identified date in December 2015 the Substitute Decision Maker (SDM) of Resident # 001 asked RPN #104 “to hold” (not administer) the regularly scheduled antiemetic as the SDM was concerned about Resident #001’s health care condition. The following day, the SDM of the Resident asked RPN #104 to continue to hold the regularly scheduled antiemetic and to also hold the regularly scheduled narcotic analgesic, as the SDM remained concerned about Resident #001’s health care condition.

On December 21, 2015 Resident #001’s Medication Administration Record (MAR) was reviewed between two identified dates in December 2015 by Inspector #161 and the Director of Care. It was documented in the December MAR that Resident #001 was not administered 6 regularly scheduled doses of the antiemetic. A review of Resident #001’s progress notes indicated that the regularly scheduled antiemetic had not been administered as per the SDM’s request. Similarly, it was documented in the December MAR that Resident #001 was not administered 4 regularly scheduled doses of the narcotic analgesic. A review of Resident #001’s progress notes indicated that the regularly scheduled narcotic analgesic had not been administered as per the SDM’s request. The progress notes also indicated that on an identified date in December 2015 Resident #001 indicated that the analgesic was not effective and requested an injection. Resident #001 complained of increased pain. The SDM was notified and permission was given to administer a single dose of the narcotic analgesic by injection. Several days later on an identified date in December 2015, Resident #001’s attending physician was made aware that the Resident had not received the regularly scheduled antiemetic and the narcotic analgesic as per the SDM’s concerns with over sedation. The attending physician decreased the freguency of the regularly scheduled narcotic analgesic which Resident #001 received.

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 health care professionals need to respect the right of a Resident to consent to treatment regardless of what others may say, when the agreed upon plan of care includes pain management strategies; and any requests for changes to the administration of prescribed drugs are discussed prior to any changes, with the prescriber to ensure that drugs are administered to Residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 14th day of January, 2016

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

Original report signed by the inspector.