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 sions 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 11, 2016	2016_330573_0008	O-002787-15	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

ANANDRAJ NATARAJAN (573)

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): April 05, 06, 07 and 08, 2016.

The following complaint and critical incident logs were inspected: Log# O-002787-15 related to a complaint regarding lack of medical attention for resident; Log# 030721-15 related to a complaint regarding resident's rights; Log# O-002222-15 related to a critical incident the home submitted regarding resident injury of unknown cause; Log# 003462-16 related to a critical incident the home submitted regarding resident to resident physical altercation with injury.

During the course of the inspection, the inspector(s) spoke with the identified resident, the resident's substitute decision maker (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Associate Director of Care (ADOC), Director of Care (DOC), Executive Director and an identified Resident's Attending Physician.

The inspector reviewed Critical Incident (CI) reports, reviewed residents health record (including care plans, progress notes, medication administration records, flow sheets, hospital discharge summaries) and the home's Pain and Symptom Management Policy and Procedure V11-G-30.10 (dated January 2015). In addition, the inspector also observed resident care and resident rooms.

The following Inspection Protocols were used during this inspection:
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The Licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.[Log# 003462-16]

On April 07, 2016, Inspector #573 conducted a critical incident inspection related to physical abuse between resident #004 and resident #005 which occurred on a specific day and time in 2016.

Resident #004 was admitted in the home on a specified date, with responsive behaviours. Resident #004 health care record indicates that for responsive behaviours, resident was assessed by the Home's Physician and by the Psycho Geriatric Team (Nurse and Physician). Medications and treatments were reassessed on an ongoing basis and readjusted to minimize the responsive behaviours.

Review of resident #004 nursing progress notes included numerous documentation of resident's wandering behaviour into other residents room in the unit. Further progress notes review identifies that the resident #004 wandered five times into resident #005 room. This included two incidents of physical altercations between resident #004 and resident #005.

The resident #004 written plan of care for wandering behaviour at the time of incident and the current plan of care in effect were reviewed by the Inspector. For wandering, it indicates resident #004 will wander within specific boundaries and the resident is encouraged to wander on the unit with walker. The plan of care failed to identify resident #004 wandering behaviour into other residents room. No specific interventions were in place to monitor the resident's whereabouts.

Resident #005 health care record was reviewed by inspector and it identifies resident #005 as having responsive behaviours. Upon review of the resident written plan of care, no interventions were noted to be in place to prevent resident #004 from entering into resident #005's room.

On April 07 and 08, 2016, Inspector #573 completed a walkabout on the residents' unit. It was observed that resident # 004's room is located next to the resident #005 room in the

same vicinity. Inspector observed no banners (wandering guard) or a stop sign placed in front of resident #005's room door.

On April 08, 2016, the Inspector spoke with RN #100, after the review of resident #004's and resident #005's plan of care. she indicated that the plan of care failed to identify resident #004's wandering behaviour into other residents room and also stated that there is no specific intervention in place in the plan of care to prevent resident #004 entering resident #005's room.

On April 08, 2016, the Inspector spoke with Director of Care (DOC), who indicated that after the incident on the specified date in 2016, interventions including wandering guard /stop signs were put in place on resident #005's room door to prevent any risk of altercations between residents. Further the DOC indicated that steps that are taken to minimize the risk of altercations between resident #004 and resident #005 were not implemented by the staff members. [s. 54. (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 steps are taken to minimize the risk of physical altercations between resident #004 and resident #005 by identifying and implementing interventions, to be implemented voluntarily.

WN #2: 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 has failed to ensure that where the Act or this Regulation required 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, is complied with. [Log# O-002787-15]

On April 05, 2016, at the request of the Inspector #573, the Associate Director of Care (ADOC) provided policy V11-G-30.10, titled Pain and Symptom Management (dated January 2015). The policy indicates that Registered Nursing Staff will conduct and document a pain assessment electronically and were required to initiate the home's 24-hour Pain and Symptom Monitoring tool (1) on admission and re-admission (2) on initiation of a PRN analgesic and when resident reports pain or symptoms of greater than 4/10 for 24-48 hours (3) when there was a change in a Resident's condition with onset of pain. Further the policy indicates that Registered Nursing Staff were required to conduct an electronic weekly pain assessment when (1) a scheduled pain medication does not relieve the pain and (2) Pain medication is changed.

Reviewed resident #001's health care record. The resident had a fall on a specified date and began to complain of pain in her/his lower back. In addition to regular pain medication, the resident was also prescribed Tylenol as needed (PRN). Tylenol PRN was administered consecutively for four days after the fall incident.

On post fall third day resident #001's health care record indicates, the resident experienced back pain, rated 10/10 and Tylenol PRN was administered. On post fall fourth day, health care record indicates that resident #001 pain medication was changed to narcotics twice daily and at a specific hours the health care record indicates resident was administered narcotics for back pain. Resident #001 health care record also indicates that resident was sent to hospital on a specific day and readmitted three days latter to the home with change in condition. Resident #001's pain medications were changed and a new medication order was in place at the time of re- admission.

Inspector #573 reviewed resident #001's health care record. There was no electronic Pain Assessment, no 24-hour Pain and Symptom Monitoring tool nor there was an electronic weekly pain assessment tool used for resident #001's pain management. No other documented pain assessment was found in the resident chart.

On April 06, 2016 the ADOC confirmed that electronic Pain Assessment, 24-hour Pain and Symptom Monitoring tool and electronic weekly pain assessment were not conducted for resident #001's pain management as per the home's Pain and Symptom Management policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident #002's substitute decision-maker was given an opportunity to participate fully in the resident #002 annual care conference. [Log# 030721-15]

Resident #002 was admitted to the home on a specified date in 2014. The resident's health record for authorization for personal assistance and consent to treatments indicates both that the resident #002 and the daughter of the resident (substitute decision maker) are the decision makers for the care.

During an interview with resident #002's substitute decision-maker (SDM), it was reported that the SDM was never invited or informed to participate in the resident's annual care conference by the interdisciplinary team.

On April 03, 2016, Inspector spoke with resident #002, who indicated that it is important to have her/his substitute decision-maker in the annual care conference meetings.

On April 03, 2016, the Inspector spoke with Director of Care, who indicated that since resident #002 is also self-responsible party for decision making, an invite was not sent to resident #002's SDM to participate in the annual care conference. [s. 27. (1) (b)]

Issued on this 11th day of April, 2016

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

Original report signed by the inspector.