Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Nov 13, 2019	2019_593573_0032	020508-19	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): October 28, 29, 30 and 31, 2019

This inspection was conducted in reference to complaint log #:020508-19 related to resident care/ services in the home.

During the course of the inspection, the inspector(s) spoke with the identified resident's family member, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Nurse Practitioner (NP), Associate Director of Care (ADOC) and Director of Care (DOC).

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

The following Inspection Protocols were used during this inspection:
Personal Support Services

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the substitute decision maker, if any, and any other persons designated by the resident or substitute decision- maker are given the opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the Ministry of Long Term -Care (MOLTC) regarding the care received by resident #001 at the LTC home.

Inspector #573 spoke with the complainant, who voiced concerns regarding resident #001's change in heath status on identified dates. Furthermore, the complainant stated that resident #001's substitute decision- maker (SDM) was not informed when there was a change in the resident's heath status.

A review of resident #001's health care record indicated that the resident was independent for most of the activities of daily living including transfers, mobility, toileting and dressing. Inspector #573 reviewed resident #001's progress notes on two specified dates, which identified that there was change in the resident's health status.

A further review of resident #001's progress notes, found no documentation that the resident #001's SDM was made aware of the resident's change in health status until when the resident was transferred to the hospital on a specified date at an identified shift.

PSW #103 indicated to Inspector #573 that on a specified date, morning they observed resident #001 was unwell and forgetful in the morning. The PSW indicated that they informed the RPN on the unit regarding the resident's change in health status. Furthermore, the PSW indicated that they observed the resident was slumped towards one side on a recliner chair and required the staff assistance for the positioning and dressing.

PSW #104 indicated to Inspector #573 that on a specified date, they observed resident #001's change in health status in the morning and required full care with the dressing and assistance with the mobility.

RPN #102 indicated to Inspector #573 that on a specified date, morning they observed resident #001's change in health status. The RPN indicated that in the morning hours resident's vitals was taken and were stable. The RPN indicated that they informed the RN in- charge regarding the resident's change in heath status and the resident was assessed by the RN. Further, the RPN stated that the resident was closely monitored. In

the afternoon hours, the nurse practitioner was notified to assess the resident. During the interview RPN #102 indicated to the inspector that resident #001's SDM was not made aware of the resident's change in health status on a specified date. Further, the RPN stated that the resident was their own power of attorney for personal care.

A review of the resident health record identified that resident #001 had SDM for the personal care. Furthermore, upon review of resident #001's health care record, it was noted that in the past resident #001's SDM was notified regarding any change in resident's care/ treatment. Furthermore, inspector noted that resident #001's SDM consent was obtained by the registered nursing staff for the resident's care and the treatments.

As such, the licensee has failed to ensure that resident #001's substitute decision-maker was given an opportunity to participate fully in the development and implementation of resident #001's plan of care. [s. 6. (5)]

Issued on this 13th day of November, 2019

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

Original report signed by the inspector.