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
Apr 21, 2021	2021_583117_0010	003399-21, 003431-21	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

LYNE DUCHESNE (117)

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): April 15, 16 and 19, 2021

During the inspection the following critical incident reports were inspected concurrently:

Log # 003399-21and Log #003431-21 : critical incidents (CIS #2879-000003-21 and #2879-000004-21) related to incidents that cause an injury to a resident for which the resident is taken to hospital and which results in a significant change in the residents' health status.

It is noted that inspector Gurpreet Gill accompanied Inspector Lyne Duchesne (#117) during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Directors of Care (ADOC), the Infection Control Program Lead, a Nurse Practitioner (NP), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), several housekeeping staff members and to several residents.

During the course of the inspection, the inspector(s) reviewed several resident health care records observed resident rooms and common area, observed fall prevention interventions and observed infection control practices.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. (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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #002 is identified as being at moderate risk for falls. The plan of care identified that staff were to monitor and provide assistance during toileting. On a specific day in 2021, the resident was left unsupervised on the toilet, fell and sustained an injury.

PSW #112 and #113 said that resident #002 needed ongoing assistance and supervision during toileting care as they were at risk of falls. PSW #113 said they left the resident unsupervised on the toilet as they went to provide assistance to RPN #111. PSW #113 and RPN #111 said that the resident got up, ambulated and fell in their room, sustaining an injury. By not following the resident plan of care, resident #002 fell and sustained an injury.

Source: Resident Health Care Record, Staff Interviews #111, #112 and #113, Critical Incident Report # 2879-000003-21 [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 22nd day of April, 2021

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

Original report signed by the inspector.