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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 25, 26, 27, Jul 9, 10, 11, 2012	2012_030150_0011	Complaint

Licensee/Titulaire de permis

SPECIALTY CARE OTTAWA INC.
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

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

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

CAROLE BARIL (150)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse, Registered Practical Nurses, Personal Support Worker (PSW), Recreational Manager, Recreational Assistant, dining room staff, residents and resident's family member.

During the course of the inspection, the inspector(s) reviewed the resident's health records, reviewed the Bowel Management Program, Skin and Wound Care Management Protocol, Pain and Symptom Assessment and Management Protocol, observed the resident, interviewed staff and residents and observed the resident activities.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Nutrition and Hydration

Pain

Personal Support Services

Recreation and Social Activities

Skin and Wound Care

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. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with s.6 (2) related to ensuring that the resident's care as set out in the plan of care was not reflective of an assessment of the resident's needs related to a positive urine test.

The home's procedure for Sending Urine Sample indicates the following:
" When the lab results are received , they are sorted by the evening RN by unit and then prioritized. Only the urgent reports will be addressed by the on-call physician, the rest of the reports are left in the unit Care Coordinator's box to be addressed, if required, the following day".

The resident #1 was newly admitted.
On an identified day in August 2011, a family member verbalized concerns about the resident crying and frequently requesting to go to the bathroom.

A urine sample was taken and sent to be analyse on an identified day in September 2011.
The final sensitivity report received 2 days later, indicated positive urine result.

The progress notes indicates on an identified day in September 2011,
"The POA called inquiring about UTI urine results, was told that the resident had a positive urine result, but that no antibiotics had been ordered, the unit could not find results, labs results located, positive urine culture and call MD, order for antibiotics received."

The Medication Administration Records (MAR) indicates that prescribed antibiotic was administered to resident#1.

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Issued on this 11th day of July, 2012

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