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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 11, 2013	2013_198117_0003	000061-13	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

LYNE DUCHESNE (117)

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): March 5, 2013, on site at the Long Term Care Home

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Associate Director of Care (ADOC), a Registered Nurse, several Registered Practical Nurses (RPNs), to several Personal Support Workers (PSWs), to several resident family members as well as to several residents.

During the course of the inspection, the inspector(s) reviewed an identified resident's health care record; examined a tub shower room; reviewed the home's Confidentiality Agreement Policy #V-B-60.0; reviewed the home's mandatory annual training program for all staff; reviewed the Clinical Practice Meeting Minutes of April 4, 2012 and reviewed the Circle of Care Minutes of July 18, 2012 for a resident care unit.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Personal Support Services

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with LTCHA s. 3 (1) 11 iv in that a resident's right to have his or her personal health information (within the meaning of the Personal Health Information Protection Act, 2004) kept confidential, and access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, was not respected on a specified day in August, 2012.

Resident #1 is identified as being capable of making their own care decisions. Documentation in the Resident's health care record notes that the Resident's legally authorized Substitute Decision Makers (SDM) are to be contacted, consulted and notified of any changes in the Resident's health status, medical interventions and treatments.

On a specified day in August, 2012, S#100 tried to contact one of the Resident's SDMs regarding a proposed medical treatment. The staff member initially called the SDM's cell phone with no success. They then called the SDM's home. An individual, who is not an SDM, answered the phone. S#100 left a message with the non-SDM individual regarding Resident #1's proposed medical treatment. The staff member also asked that the SDM call back the home regarding this medical treatment. S#100 stated that this is the only instance in which Resident #1's personal health information was shared with a non-authorized individual. Resident #1's two SDMs stated that this is the only instance to their knowledge in which Resident #1's personal health information was shared with a non-authorized individual.

S#100 failed to keep Resident #1's personal health information confidential by divulging information related to a proposed medical treatment to an individual who is not a legally authorized Substitute Decision Maker (SDM) and who is not authorized to receive Resident #1's personal health information. [s. 3. (1) 11. iv.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with O.Reg 79/10 s. 33 (1) in that a resident was not bathed, by the method of his or her choice, on specified day in July, 2012.

Resident #1 plan of care identifies that the resident prefers to have a shower, twice a week. The shower is to be given in the tub with the use of a hand held shower. Interviewed staff state that they are aware that Resident #1 is known to have leg pains which are exacerbated when the legs are submerged in water. Nursing staff are aware of Resident #1's preference to have a shower and that the tub water drains so as not to submerge the Resident's legs in water.

On a specified day in July, 2012, Resident #1 was given a shower. The shower was given in the tub, with the aid of a hand held shower. During the course of the shower, the Resident experienced leg pains and discomfort. Resident#1 felt that their legs were submerged in water. Resident #1 expressed dissatisfaction with their shower to one of their family members after the shower. One of the resident's SDMs reported the incident to the unit RPN. An internal investigation found that the PSW had not ensured that the tub drain was open. The tub drain was closed, which led to the accumulation of water in the tub, and the Resident's legs being submerged in water, causing pain and discomfort.

Since then, the Resident has not reported to their family or to nursing staff any other concerns related to their choices and preferences during the provision of showers and baths.

Resident #1's preferences and method of showering were not respected on a specified day in July, 2012 when Resident #1's legs were submerged in water during a shower. [s. 33. (1)]

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Issued on this 12th day of March, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Lynne Duchesne #117