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

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
Dec 23, 2013	2013_128138_0051	O-001004-13 O-001027-13	Critical Incident System

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

PAULA MACDONALD (138)

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): December 18 and 20, 2013

The home has recently changed its name and its licensee information. The home's name is now Granite Ridge and the licensee information is The Royale Development GP Corporation as general partner of The Royale Development LP.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, the Director of Care, a registered practical nurse, and the Care Coordinator.

During the course of the inspection, the inspector(s) reviewed two Critical Incident Reports, reviewed several resident health care records, reviewed the home's policy on abuse, reviewed employee training requirements, and reviewed internal investigation documents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O 2007, c.8, 23. (2) in that the licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

In accordance with LTCHA 2007 s. 23. (1) (a) (i) and 23. (2) the licensee of a long term care home shall ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated and that the licensee shall report to the Director the results of every investigation undertaken and every action taken.

Long Term Care Homes Inspector #138 reviewed two Critical Incident Reports (2879-000025-13 and 2879-000026-13) that outlined two separate incidents of staff to resident abuse, one occurring on October 17, 2013 and the second occurring on October 19, 2013. The first incident of staff to resident abuse that had occurred on October 17, 2013 was investigated immediately and concluded with the staff member receiving a one day suspension on October 21, 2013 and retraining that was completed on November 13, 2013. The second incident of staff to resident abuse occurred on October 19, 2013 and was reported by the resident on October 20, 2013. Immediate actions were taken and the investigation concluded with the staff member receiving a one day suspension on November 14, 2013.

LTCH Inspector met with the home's Administrator on December 18, 2013 regarding the two incidents. The Administrator stated that he did not communicate the results of either of the investigations. [s. 23. (2)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O 2007, c.8, 24. (1) 1. in that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to a resident did not immediately report the suspicion and the information upon which it is based to the Director.

Long Term Care Homes Inspector #138 reviewed Critical Incident Report (2879-000026-13) that outlined staff to resident abuse in which a staff member was rough with a resident when providing care. The resident received bruising to his finger. The unit registered practical nurse, the Critical Incident, and the progress notes for the resident indicated that the incident occurred the morning of October 19, 2013. The incident was reported by the resident to the unit registered practical nurse the morning of the following day on October 20, 2013. The Administrator stated that the incident was reported to the Director through the Ministry's Critical Incident System which was two days later on October 22, 2013. [s. 24. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O 2007, c. 8. s. 76. (4) in that the licensee failed to shall ensure that the persons who receive training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulation.

In accordance with LTCHA 2007 section 76. (1), 76. (2) 3., 76. (4) and Ontario Regulation 79/10 section 219. (1) the licensee shall ensure that all staff at the home receive training as required on the long term care home's policy to promote zero tolerance of abuse and neglect of residents and that all persons who received this training receive retraining annually.

Long Term Care Homes Inspector #138 reviewed Critical Incident Report (2879-000026-13) that outlined staff to resident abuse in which a staff member was rough with a resident when providing care resulting in bruising to the resident's finger. The home suspended the staff member for the incident. The LTCH Inspector requested to reviewed the staff member's annual training record and the home was unable to demonstrate that the staff member received the last annual training on the home's abuse policy. The Director of Care stated that the staff member had not received her last annual training due to several leaves of absences. Further discussion was held with the Director of Care regarding the annual training of abuse and the Director of Care stated that the training is conducted on-line and available to staff at any time. [s. 76. (4)]

Issued on this 23rd day of December, 2013

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

Paula MacDonald RD