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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 1, 2017	2017_582548_0009	006437-17, 009089-17	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

RUZICA SUBOTIC-HOWELL (548)

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): on May 29,30 and 31, 2017

Critical incident reports (CIR):
Log:006437-17 - related to alleged staff to resident abuse
Log:009089-17- related to resident to resident physical abuse

During the course of the inspection the inspector observed staff to resident interactions, resident to resident interactions, reviewed resident health care records and the home's investigative notes.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care, Assistant Director of Care, Registered Nurse, Registered Practical Nurses, Personal Support Workers.

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

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	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. 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 immediately report the suspicion and information of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

A Critical Incident Report (CIR) was submitted in March 2017 to the Director under the Long-Term Care Homes Act (LTCHA), 2007 describing an incident of alleged staff verbal and physical abuse to resident #003.

On May 30, 2017 during an interview with Inspector #548 Registered Practical Nurse (RPN) #106 indicated that she responded to a call bell and found resident #003 to be upset stating Personal Support Worker (PSW) #108 had been rude grabbing the resident's phone and throwing it down on the bed while making statements that it was too late to make a call. She indicated that the resident gestured how PSW #108 grabbed the phone and threw it down. She informed the charge Registered Nurse (RN) #107 of the incident.

On May 31, 2017 during an interview with the Inspector #548 RN #107 indicated that she became aware of the incident at approximately 2130 hours when she received call from RPN #106. She indicated that she found resident #003 to be shaky and visibly upset providing details of the incident. She indicated that the resident indicated to her that the phone was taken and thrown down on the bed, twice. Each time the resident was

informed by the PSW #108 that he/she was not to make a call.

On May 31, 2017 during an interview with Inspector #548 the resident #003 indicated the incident was distressful and he/she was not wanting to further discuss.

Phone records were reviewed by Inspector #548 and a call was placed from the resident's room at a specified time on the day of the alleged incident.

On May 30, 2017 during an interview PSW #108 indicated that he works the evening shifts from 1500 to 2300 hours regularly and has cared for the resident in the past. On the evening of the alleged incident he indicated that he responded to the ringing of the resident's #003 chair alarm. Entering the resident's room he observed the resident attempting to rise out of chair. He reattached the alarm and left the resident's room. He does not recall if the resident was on the phone. He indicated he was unaware of the incident as described by the resident until he was approached by RPN #106.

On May 30, 2017 during an interview with the Inspector #548 the Director of Care (DOC) indicated there is a procedure to report incidents of alleged, suspected and witnessed abuse. She explained the reporting of incidents involves all staff to report to their supervisor and to inform a registered nurse (RN). Additionally, there is a charge RN who is responsible to respond to incidents in the absence of the Administrator or Directors of Care(s). A component of home's reporting procedure involves the charge RN to inform the on-call manager. She further indicated the charge nurse represents the home and Licensee. On the same day during an interview with the Inspector #548 the Assistant Director of Care (ADOC) indicated the on-call manager had not been informed by the Charge RN #110 of the incident, as required.

On May 31, 2017 RN #107 indicated that she is aware of reporting requirements however, as the resident was safe at the time she determined that the incident could be communicated to the ADOC in an email. She indicated she was aware of reporting requirements to the on-call manager.

An email was sent from RN #107 to the ADOC on the evening of the alleged incident, describing the incident. The ADOC indicated she reviewed the email the following morning and was unable to indicate the reason for not immediately reporting the incident.

The Licensee failed to immediate report to the Director the allegation of verbal and physical abuse from PSW #108 to resident #003 until 24 hours after the incident. [s. 24.

(1)]

Issued on this 2nd day of June, 2017

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

Original report signed by the inspector.