Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long- Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: January 18, 2023

Inspection Number: 2022-1364-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP

Long Term Care Home and City: Granite Ridge Care Community, Stittsville

Lead Inspector	**Inspector Digital Signature**
Sarabjit Kaur (740864)	Sarabjit Kaur Digitally signed by Sarabjit Kaur Date: 2023.02.17 14:56:58 -05'00'

Additional Inspector(s)
Cheryl Leach (719340)
Anandraj Natarajan (573)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 23- November 25, 2022
November 28- December 02, 2022
December 05- December 06, 2022

The following intake(s) were inspected:

- Intake: #00001020-[CI: 2879-000046-22] Missing Resident for less than 3 hours
- Intake: #00003423-[CI: 2879-000049-22] Fall of resident resulting in significant change in health status
- Intake: #00003934-[CI: 2879-000051-22] Fall of resident resulting in significant change in health status
- Intake: #00005088-[CI: 2879-000056-22] Fall of resident resulting in significant change in health status
- Intake: #00005775-[AH: IL-04618-AH/CI: 2879-000062-22] Resident to resident alleged physical abuse

- Intake: #00007889-[IL: IL-05486-OT]Anonymous complaint regarding several areas of care and services.
- Intake: #00008257-IL-05644-AH/2879-000074-22 Resident to resident alleged sexual abuse
- Intake: #00008548-IL-05763-AH /2879-000077-22 - Resident to resident alleged sexual abuse.
- Intake: #00009178-IL-06054-AH /2879-000080-22 -Resident to resident alleged sexual abuse.
- Intake: #00012343-2879-000088-22 Complainant's concerns related to alleged abuse.
- The following intakes were completed in this inspection: Intake# 0000102, CI# 2879-000044-22, Intake# 00002351, CI# 2879-000039-22, Intake# 00008322, CI# 2879-000073-22. Intake #0003423, CI#2879-000049-22 and Intake #00005088, CI#2879-000056-22, Intake# 00003934, CI#2879-000051-22 were related to an injury with a significant change in condition

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Restraining by physical devices

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (1)

The licensee has failed to ensure that a resident may be restrained by a physical device as described in paragraph 3 of subsection 34 (1) if the restraining of the resident is included in the resident's plan of care.

Rationale and Summary
Resident #004 sustained a fall and was transferred to the hospital and as a result had an injury with a significant change. Resident's plan of care indicates that resident #004 has a Personal Assistive Service Device (PASD) for repositioning and resident is able to self propel for locomotion on the unit.
Inspector observed that resident #004's PASD was in use by PSW #109. During the interview PSW #109 confirmed that they used the PASD to stop the resident from self propelling and falling. PSW #109 further added that resident #004 still tries to climb out of the wheelchair when the PASD is in use.
Restraining the resident using the PASD can cause a moderate risk of falls as resident #004 can try to climb out of the wheelchair leading to falls.

Sources: Plan of care, observation, Interview with DOC and other staff

[740864]

WRITTEN NOTIFICATION: Plan of care -Reassessment, revision

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

1.The licensee has failed to ensure that when resident #005 was reassessed and the plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

Rationale and Summary: A review of resident #005's health care record identified that the resident had a history of inappropriate sexual behaviours. An intervention was initiated and was followed up with the psycho geriatric team. Resident #005's plan of care identified the resident's sexual behaviours and interventions to manage their behaviours.

Progress notes indicated that resident #005 exhibited inappropriate sexual behaviours towards resident #010. Progress notes documentation indicated that behaviour mapping and 15 minutes checks was initiated to monitor resident #005's sexual behaviour. Progress notes after the first incident indicated that resident #005 exhibited inappropriate sexual behaviours towards resident #006 for a second time. Progress notes documentation indicated that the behaviour mapping was reinitiated, and 15 minutes checks were continued with resident #005. Progress notes indicated that resident #005 exhibited inappropriate sexual behaviours towards resident #011. Progress notes documentation indicated that a new intervention was initiated following the third incident and behaviour mapping continued for resident #005.

PSW #126 indicated that they are aware of resident #005's sexual behaviours towards other residents on the unit. PSW #126 stated that the interventions in place for resident #005's sexual behaviours on were not effective in managing their behaviours.

RN #125 stated that the interventions in place for resident #005's sexual behaviours were not effective since the incidents reoccurred. RN #125 indicated that the interventions were not effective until the new intervention was initiated. Staff failed to consider different approaches when the care set out for resident #005 was not effective in managing the resident's sexual behaviours resulted in actual harm.

Sources: Health care records, and interview with PSW #126 and RN #125. [573]

Non-compliance with: FLTCA, 2021 *s.6 11(b)*

2.The licensee has failed to ensure that care set out in resident #007's plan is effective and different approaches are considered in the revision of plan of care.

Rationale and Summary
Record review indicated that resident #007 had multiple incidents where they were trying to elope from the home and were successful in eloping . After the first incident, resident #007 was on every 15 minute monitoring and the unit doors were locked. After several incidents, the interventions were not re-assessed and the resident #007 finally eloped. Interview with the DOC confirms that interventions put in place for resident #007 were not effective as resident

was able to elope.
This puts the resident at moderate risk related to their safety.[740864]

Sources: Record review of plan of care, Interview with the DOC [740864]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the safety device for resident #004 as set out in the plan of care is used as specified in the plan.

Rationale and Summary
Resident #004 sustained a fall and was transferred to the hospital resulting in significant injury.
Resident's plan of care indicates that resident #004 required to have a safety device as a fall prevention strategy.
Observation showed that resident #004 did not have the safety device in place when they were sitting in the wheelchair.
RPN #110 confirmed that resident #004 should have a safety device as per the plan of care and it was not found during observations with RPN #108.
This puts the resident at moderate risk for safety as fall interventions are not in place as specified in the plan of care.
Sources: Record review of resident#004's plan of care, observations, Interview with RPN #110 [740864]

WRITTEN NOTIFICATION: Notification re incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 104 (1) (b)

The licensee has failed to ensure that resident #006's substitute decision-maker (SDM) was notified within twelve hours upon the licensee being made aware of an alleged incident of abuse.

Rationale and Summary: A review of Critical Incident Report (CIR) #2879-000077-22 reported alleged sexual abuse toward resident #006. A review of resident #006's health care record indicated that the resident's SDM was not notified of an alleged sexual abuse incident.

RN #125 indicated that the alleged incident of sexual abuse toward resident #006 was not reported to resident #006's SDM.

Sources: Critical Incident Report (CIR) #2879-000077-22, health care record and interview with RN #125. [573]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (4) (c)

The licensee failed to ensure that when resident #005 demonstrated responsive behaviours, that actions were taken to respond to the resident needs, including assessment, reassessments, interventions, and that the resident's responses to interventions are documented.

Rationale and Summary: A review of resident #005's plan of care identified that the resident exhibits inappropriate sexual behaviours. A review of the resident's health care record indicated that on resident exhibited sexual behaviour toward other residents on the unit. Resident #005's progress notes documentation indicated that behaviour mapping was reinitiated following an incident. The inspector reviewed resident #005's behaviour mapping tool and noted that the behaviour mapping documentation was not completed.

Inspector spoke with the DOC, they acknowledged that the behaviour mapping tool for resident #005 was not completed.

Sources: resident #005's health care records, behaviour mapping tool and interview with the DOC. [573]

COMPLIANCE ORDER CO ##001 Infection Prevention & Control Standard

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee shall:

A. Educate PSWs #116, #114, #120, Housekeeper #122 and RPN #113 on hand hygiene and PSW # 115 on proper mask application as per evidence based best practice standards.
B. Perform weekly audits to ensure that staff are following the licensee's Infection and Prevention Program with regards to: Hand hygiene and ensuring proper mask application. The audits are to be conducted until consistent compliance to the Infection and Prevention Program described above is demonstrated.
C. Take corrective actions to address staff non-compliance related to hand hygiene and proper application of masks as identified in the audits.
D. Written records of A, B and C shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
Non-compliance with: O. Reg. 246/22 s.102(2)(b)
The licensee has failed to ensure that Infection Prevention and Control standard issued by the director was followed by staff related to hand hygiene and personal protective equipment.

Rationale and Summary
Observations of PSW #114 PSW #116 and Housekeeper #122 on Nov 23, 2022 showed that proper hand sanitization was not performed. PSW #114 did not sanitize their hand between the handling of dirty and clean linen. PSW #116 did not sanitize their hands after removing soiled gloves and housekeeper #122 did not sanitize their hands before entering the resident's environment. PSW #120 did not sanitize their hands when feeding residents at different tables.

RPN# 113 did not perform hand hygiene during medication administration. PSW #115 was wearing their mask below their nose when they were close to the resident's face.
IPAC Lead #117 confirmed that staff needs to sanitize their hands before entering a resident environment, during medication administration and when moving between tables to feed different residents.
Sources: Interview with IPAC Lead #117 and other staff, observation by Inspector #740864 Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes[740864]

This order must be complied with by March 1, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.