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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: March 27, 2024
Inspection Number: 2024-1364-0001
Inspection Type: Critical Incident
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP
Long Term Care Home and City: Granite Ridge Community, Stittsville

Lead Inspector	**Inspector Digital Signature**
Linda Harkins (126)	Linda Harkins Digitally signed by Linda Harkins Date: 2024.03.28 12:25:14 -04'00'

Additional Inspector(s)
Lisa Cummings (756)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 5, 6, 7, 8, 11, 12, 13, 15, 18, 19, 20, 21, 25, 26, 27, 2024
The inspection occurred offsite on the following date(s): March 11, 14, 2024

The following intake(s) were inspected:

- Intake: #00103991 Critical Incident (CI) 2879-000069-23 An allegation of staff to resident neglect
- Intake: #00103988 CI #2879-000068-23 A fall that caused an injury and required a transfer to hospital
- Intake: #00104369 CI #2879-000076-23 An allegation of physical abuse resident to resident

- Intake: #00104444 CI #2879-000074-23 An allegation of sexual abuse resident to resident
- Intake: #00104721 CI #2879-000079-23 An allegation of physical abuse resident to resident
- Intake: #00104906 CI #2879-000001-24 An allegation of physical abuse resident to resident
- Intake: #00105012 CI #2879-000085-23 An allegation of sexual abuse resident to resident
- Intake: #00105362 CI #2879-000084-23 A written complaint related to resident's care and allegation of neglect
- Intake: #00105783 CI #2879-000002-24 An allegation of sexual abuse resident to resident
- Intake: #00105810 CI #2879-000003-24 An allegation of physical abuse resident to resident
- Intake: #00106293 CI #2879-000005-24 An allegation of sexual abuse resident to resident
- Intake: #00107182 CI #2879-000010-24 An allegation of sexual abuse resident to resident
- Intake: #00108487 CI #2879-000013-24 An allegation of physical abuse resident to resident
- Intake: #00108510 CI #2879-000014-24 An allegation of sexual abuse resident to resident
- Intake: #00109133 CI #2879-000015-24 An allegation of physical abuse resident to resident
- Intake: #00109624 CI #2879-000016-24 An allegation of physical abuse resident to resident
- Intake: #00109886 CI #2879-000019-24 An allegation of physical abuse resident to resident
- Intake: #00110044 CI #2879-000020-24 Outbreak
- Intake: #00110272 CI #2879-000021-24 An allegation of improper care/treatment

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

Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

1) The licensee has failed to ensure that an allegation of sexual abuse was immediately reported to the Director. An incident occurred on a specific date was

not reported to the Director.

Sources: Interview with Director Of Care (DOC) and record review.
[126]

2) The licensee has failed to ensure that an allegation of sexual abuse was immediately reported to the Director. An incident occurred on a specific date and was reported to the Director the following day.

Sources: Interview with Assistant Director Of Care (ADOC) and record review.
[126]

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

1) The licensee has failed to ensure that a behavioural trigger for a specific resident was documented in the plan of care.

Sources: Resident's Care plan and interview with Registered Practical Nurses (RPNs)
[126]

2) The licensee has failed to ensure that a behavioural trigger for a specific resident was documented in the plan of care.

Sources: Care plan, interviews with Personal Support Workers (PSW) and ADOC.
[756]

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The licensee has failed to send a follow-up response. A written complaint was received on specific date and a care conference was held two weeks later. No response follow up letter was sent to the complainant.

Sources: Complaint letter and Acknowledgment letter and interview with the Director of Resident and family Relations.
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