

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 2, 2024	
Original Report Issue Date: June 10, 2024	
Inspection Number: 2024-1364-0003 (A1)	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP	
Long Term Care Home and City: Granite Ridge Community, Stittsville	
Amended By Lisa Cummings (756)	Inspector who Amended Digital Signature

AMENDED INSPECTION SUMMARY

This report has been amended to reflect an extension to the compliance due date for Compliance Order #001 to August 19, 2024. An extension to the compliance due date was requested by the licensee and has been approved. The original compliance due date was July 19, 2024.

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Lead Inspector Lisa Cummings (756)	Additional Inspector(s) Linda Harkins (126) Dee Colborne (000721) Karen Bunes (720483) Lisa Kluge (000725)
Amended By Lisa Cummings (756)	Inspector who Amended Digital Signature

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15, 16, 17, 21, 22, 23, 24, 27, 28, 29, 2024 and June 3, 4, 5, 6, 7, 10, 2024

The inspection occurred offsite on the following date(s): May 16, 24, 2024

The following intake(s) were inspected:

- Intake: #00105874 - Follow-up #: 1 - FLTCA, 2021 - s. 28 (1) 2. regarding reporting to the Director
- Intake: #00105875 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1) regarding duty to protect
- Intake: #00105876 - Follow-up #: 1 - O. Reg. 246/22 - s. 58 (1) 1. regarding responsive behaviours
- Intake: #00109624 (CI #2879-000016-24) - An allegation of resident to resident physical abuse
- Intake: #00110281 (CI #2879-000022-24) - An allegation of resident to resident physical abuse
- Intake: #00110507 - A complaint with concerns regarding availability of supplies, staff training, and skin and wound care
- Intake: #00111013 (CI #2879-000025-24) - Regarding an unexpected death
- Intake: #00111471 (CI #2879-000026-24) - An allegation of resident to resident physical abuse
- Intake: #00111484 and #00114703 - Complaints regarding personal care, availability of supplies, resident's council, housekeeping, the complaint response process and an allegation of staff to resident emotional abuse
- Intake: #00111731 (CI #2879-000027-24) - An allegation of neglect
- Intake: #00111744 (CI #2879-000028-24) - An allegation of staff to resident emotional abuse
- Intake: #00111809 (CI #2879-000029-24) - Regarding a confirmed respiratory outbreak

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- Intake: #00112393 (CI #2879-000031-24) - An allegation of resident to resident sexual abuse
- Intake: #00113727 (CI #2879-000036-24) - An allegation of staff to resident emotional abuse
- Intake: #00114230 (CI #2879-000039-24) - An allegation of resident to resident physical abuse
- Intake: #00114607 (CI #2879-000040-24) - An allegation of resident to resident physical abuse
- Intake: #00114818 (CI #2879-000044-24) - An allegation of resident to resident physical abuse
- Intake: #00114917 (CI #2879-000045-24) - An allegation of resident to resident sexual abuse
- Intake: #00115636 (CI #2879-000047-24) - An allegation of resident to resident physical abuse
- Intake: #00115675 (CI #2879-000048-24) - An allegation of neglect
- Intake: #00115731 - A complaint regarding housekeeping and bed linens

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1364-0009 related to FLTCA, 2021, s. 24 (1) inspected by Linda Harkins (126)

Order #002 from Inspection #2023-1364-0009 related to O. Reg. 246/22, s. 58 (1) 1. inspected by Lisa Cummings (756)

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Order #003 from Inspection #2023-1364-0009 related to FLTCA, 2021, s. 28 (1) 2.
inspected by Lisa Cummings (756)

The following Inspection Protocols were used during this inspection:

- Resident Care and Support Services
- Continence Care
- Skin and Wound Prevention and Management
- Residents' and Family Councils
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Reporting and Complaints
- Residents' Rights and Choices

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

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Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care was documented in the resident's written plan of care. Specifically, the resident's written plan of care did not include that 1:1 staffing was assigned for all shifts to manage responsive behaviours.

Sources: Observations, progress notes, written plan of care, 1:1 documentation, interviews with a Sitter, a Registered Practical Nurse (RPN) and an Associate Director of Care (ADOC).

The licensee added the 1:1 intervention to the resident's written plan of care prior to the conclusion of the inspection.

[000721]

Date Remedy Implemented: June 4, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard issued by the Director was implemented. Specifically section 10.1 of the IPAC Standard states that Alcohol Based Hand Rub (ABHR) shall be easily accessible in the common areas. The ABHR dispensers at the entrance of a resident

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home area and outside of a resident room were not functioning.

Sources: Observation on the resident home area, interview with a Housekeeper.

The Director of Environmental Services replaced the ABHR dispensers in the common areas of the resident home area prior to the conclusion of the inspection.
[756]

Date Remedy Implemented: June 6, 2024

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)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care related to a treatment of a resident was provided to the resident as specified in the plan. Nursing interventions were documented in the Digital Prescribers' Orders and these interventions were processed and implemented three days later.

Sources: Digital Prescriber's Orders, progress notes and care plan.

[126]

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

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NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 19 (2) (a)

Accommodation services

s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

1) The licensee has failed to ensure that the home equipment such as fall mats were kept clean and sanitary. On two dates, the floor mats in three resident rooms were observed to be dirty with white matters.

Source: Observations.

[126]

2) The licensee has failed to ensure that home equipment, such as fall mats, were kept clean and sanitary. On two dates, the fall mats in two resident rooms were observed to be dirty with white matter.

Sources: Observations, Interview with the Director of Environmental Services.

[756]

3) The licensee has failed to ensure the equipment was kept clean and sanitary, specifically the ABHR dispensers in a stairwell.

Sources: Observations.

[720483]

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

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NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

Accommodation services

s. 19 (2) Every licensee of a long-term care home shall ensure that,

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the door frame in a resident room was kept in good state of repair.

Source: Observation.

[126]

WRITTEN NOTIFICATION: Policy to promote zero tolerance of abuse

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy for abuse was complied with. Specifically, the injury of a resident by another resident was not immediately reported to the charge nurse at the time of the noted injury as per the licensee's abuse policy.

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Sources: Progress notes, head to toe assessment, Prevention of Abuse and Neglect policy. Interviews with a Registered Practical Nurse (RPN), and two Registered Nurses (RN).

[000721]

WRITTEN NOTIFICATION: Reporting of critical incidents

NC #007 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.

The licensee has failed to immediately report an alleged incident of resident to resident abuse.

Sources: Progress notes, risk management report, interview with an RPN.

[000721]

WRITTEN NOTIFICATION: Doors in a home

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

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3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

1) The licensee has failed to ensure that the nursing office door was closed while it was not supervised by staff.

Sources: Observation and interview with a Personal Support Worker (PSW).
[126]

2) The licensee has failed to ensure that the nursing office door was closed while it was not supervised by staff.

Sources: Observation and interview with a PSW.
[126]

3) The licensee has failed to ensure that the nursing office door was closed when left unsupervised.

Sources: Observation, interview with an RPN.
[756]

WRITTEN NOTIFICATION: Reports re: Critical Incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each

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of the following incidents in the home, followed by the report required under subsection (5):

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that the Director was immediately notified of an unexpected death of a resident.

Sources: Critical Incident (CI-2879-000025024), After Hours report (IL-0123931), Progress notes, death certificate, interviews with an RPN and an RN. [000721]

COMPLIANCE ORDER CO #001 Housekeeping

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A) Provide training to Housekeeper #122 on the housekeeping procedure for

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resident rooms on the resident home area.

B) The resident rooms on the home area will be cleaned and disinfected as per the housekeeping procedure each day and the tasks completed will be documented.

C) Develop and complete a twice weekly audit of the resident rooms on the home area. The audits shall be completed for at least four weeks and until consistent compliance is achieved.

D) If the resident rooms are found to be visibly soiled during the twice weekly audits, immediate corrective action shall be taken.

E) A record must be kept of everything required under (A), (B), (C), and (D) until the Ministry of Long-Term Care has determined the licensee has complied with this order.

Grounds

The licensee has failed to ensure the housekeeping procedure for cleaning resident bedrooms on the resident home area was implemented.

The housekeeping assignment identified that all vertical and horizontal surfaces in resident bedrooms should be cleaned and disinfected and that the floors in resident rooms should be dry or damp mopped. On two dates, the two fall mats in a resident room was observed to be have a large amount of white matter on them and there was dirt along the perimeter and corners of the bedroom floor. On the same dates, the three fall mats in another resident room were observed to have a large amount of white matter on them, there was dirt along the perimeter and corners of the floor, and the bedside light for one of the bed's had a thick layer of dust on it.

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The Director of Environmental Services stated the cleaning of fall mats was included in the housekeeping assignment and that the tasks listed in the housekeeping assignment should be completed each day. The Housekeeper for the resident home area stated they were not aware the fall mats were their responsibility to clean and they did not have enough time to complete all housekeeping tasks as they were assigned to two resident home areas.

Sources: Observations, Housekeeping assignment, and interviews the Housekeeper and the Director of Environmental Services.

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This order must be complied with by August 19, 2024

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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

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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:



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

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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.