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: August 13, 2024
Inspection Number: 2024-1364-0004
Inspection Type: Complaint 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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 22, 23, 24, 25, 26, 29, 30, 31, 2024 and August 1, 2, 6, 7, 8, 9, 2024

The following intake(s) were inspected:

- Intakes #00113747, #00114668, #00115877, #00116252, #00117720 related to dealing with complaints.

- Intakes #00116133, #00116236, #00116664, #00119530, #00120385, #00120656, #00121791, #00121791 related to an allegation of resident to resident abuse.

- Intakes: #00118150, #00118859, #0011887 related to an allegation of sexual abuse resident to resident.

- Intakes: #00119881 -Complaints related to resident's cares, bed time routine, supplies and continence care and #00120397 related to supplies and plan of care.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Continence Care
Medication Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints

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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care provided clear directions to staff and others who provided direct care to a resident related to eating. The resident required assistance at times and it was not documented in the plan of care.

Sources: Interview with an Assistant Director Of Care (ADOC) and a Registered Practical Nurse (RPN) and the plan of care

The plan of care was updated to reflect that the resident required assistance with eating if needed.

Date Remedy Implemented: August 8, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246 / 22, s. 115 (1) 5.
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 of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to immediately report to the Director a Covid Outbreak which was confirmed on a specific date.

Sources: Interview with the Director of Care (DOC) and a Critical Incident Report

(CIR).

The Critical Incident was submitted the following morning.

Date Remedy Implemented: August 7, 2024

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the plan of care for a resident set out clear direction, on how to manage the resident's specific care needs in order to assist the resident with activities of daily.

Sources: resident's electronic health record, Interviews with two Personal Support Workers (PSW)s and an ADOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 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.

1) The licensee has failed to ensure that the written policy, titled zero tolerance of abuse and neglect of residents, that was in place, was complied with upon suspicion of alleged abuse of a resident.
Specifically the licensee has failed to comply with their policy, titled Prevention of Abuse & Neglect of a Resident, V11-G-10.00, with last revised date October 2023, which contained in the Procedure on page 2 that:
If any team member or volunteer witnesses or suspects an incident of abuse of a resident by anyone, or neglect of the resident by the community or one of its team members, or has any knowledge of such an incident, that team member or volunteer is responsible to immediately take these steps:
3) Immediately inform the Nurse in charge in the community.
The Investigation (initiated and coordinated by the Executive Director or designate): page 3
2) The Executive Director or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.
3) The alleged abuser is also asked to write, sign and date a statement of the event.

Sources: Policy ID 14575679 with Last Revised date October 2023. Prevention of Abuse & neglect of a Resident V11-G-10.00, record of interview with a PSW and interviews with the PSW and an ADOC.

2) The licensee has failed to ensure that the written policy, titled zero tolerance of abuse and neglect of residents, that was in place, was complied with upon receipt of a complaint of alleged neglect of a resident.

Specifically the licensee has failed to comply with their policy, titled Prevention of Abuse & Neglect of a Resident, V11-G-10.00, with last revised date October 2023, which contained in the Procedure on page 3 that:
1.The Executive Director or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.
Procedure: Page 4
1.All investigative information is kept in an investigation report that is separate from the resident's clinical administrative record.

Sources: Policy ID 14575679 with Last Revised date October 2023. Prevention of Abuse & neglect of a Resident V11-G-10.00, Home's file for a Critical Incident Report (CIR), interview with the DOC..

3) The licensee has failed to ensure that the written policy, titled zero tolerance of abuse and neglect of residents, that was in place, was complied with, when notified of the suspicion of the alleged abuse of a resident.
Specifically the licensee has failed to comply with their policy, titled Prevention of Abuse & Neglect of a Resident, V11-G-10.00, with last revised date October 2023, which contained in the Procedure that:
2) The Executive Director or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation. (Page 3)
5) All investigative information is kept in an investigation report that is separate from the resident's clinical and administrative records. (Page 4)

Sources: Policy ID 14575679 Prevention of Abuse & neglect of a Resident V11-G-

10.00., interview with an ADOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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 the alleged incident of resident neglect was immediately reported to the Director.

Sources: An Info Line (IL) report, CIR , Interviews with an ADOC and with a RPN.

2) The licensee has failed to immediately report an alleged incident of neglect of a resident by a RPN, to the Director.

Sources: A CIR, the complaint record and a interview with two ADOCs.

3) The licensee has failed to ensure that the suspected incident of alleged resident abuse was immediately reported to the Director.

Sources: An IL Report, a CIR, an interview with a RPN and an ADOC.

WRITTEN NOTIFICATION: Doors in a home.

NC #006 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:
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.

The licensee has failed to ensure that the door leading to a Soiled Utility room, a non-residential area, was closed and locked when they are not being supervised by staff.

Source: observation of the door

WRITTEN NOTIFICATION: Bedtime and rest routines

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 45
Bedtime and rest routines
s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The licensee has failed to ensure that a resident desired bedtime was followed. A resident was observed to be in bed in pajamas with the light off at 1858hrs. The resident desired bedtime as per the plan of care was 2100hrs.

Sources: Observation and interview of the resident, an interview with the DOC and

record review of the plan of care.

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 3. i.
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:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010 was included in the response letter to the complainant related to the alleged neglect of a resident.

Sources: CIR, a follow up letter to the complainant and an interview with the DOC.

WRITTEN NOTIFICATION: Dealing with complaints.

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (2) (a)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint;

The licensee has failed to ensure that a documented record is kept in the home that included the nature of a verbal complaint that the home received, that involved a resident, regarding an alleged abuse and neglect by staff.

Sources: CIS, response made in turn by the complainant, the licensee's documented record of complaints and an interview with the DOC.

WRITTEN NOTIFICATION: Dealing with complaints.

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (2) (b)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(b) the date the complaint was received;

The licensee has failed to ensure that a documented record is kept in the home that included the date the complaint was received, that involved a resident regarding alleged abuse and neglect by staff .

Sources: CIR, response made in turn by the complainant, licensee's documented record of complaints and an interview with the DOC.

WRITTEN NOTIFICATION: Dealing with complaints.

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (2) (f)

Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(f) any response made in turn by the complainant.

The licensee failed to ensure that a documented record included the response made in turn by the complainant, that the home received, that involved a resident regarding alleged abuse and neglect by staff.

Sources: CIR, response made in turn by the complainant, licensee's documented record of complaints and an interview with the DOC.

WRITTEN NOTIFICATION: Medication management system

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the "Documentation of Narcotic and Controlled Medication Counts Policy (7.5)" reviewed November 30, 2023, was implemented . The policy requires under Option A: Combined Narcotic / Controlled Medication Count record;

"5. When administering the Narcotic / Controlled medication, nurse documents for the administration of the medication on the resident's MAR and on the Combined

Narcotic / Controlled Medication Count Record.
6. Sign on the Combined Narcotic / Controlled Medication Count Record each time a dose is administered. Include the date, time, amount given, amount wasted, and quantity remaining on hand. Another nurse is required to witness and sign for wasted amounts of Narcotic / Controlled medications when applicable. "

The licensee has failed to ensure that the "Combined Narcotic / Controlled Medication Count Record' was signed after administering narcotics as per policy.

Sources: Observation and interviews with a RPN and a Nursing Student.

WRITTEN NOTIFICATION: Construction, Renovation, etc., of Homes

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 356 (3) 1.
Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.

The licensee has failed to ensure that renovations due to water damage in a shower room on a resident home area, received approval of the Director prior to commencing.

Sources: Observations of a shower room on the resident home area and interviews with the Administrator and with the Environmental Services Manager.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A. Educate all staff on performing hand hygiene as per best practices, prior to entering and when exiting a resident home area, specifically when the doors are kept closed.
B. Perform weekly audits to ensure that staff are following the licensee's Infection and Prevention Program with regards to: Hand hygiene. The audits are to be conducted until staff are demonstrating compliance with A.
C. Corrective actions to be taken with staff who are not performing hand hygiene. prior to entering and when exiting a unit with the door closed
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
The licensee has failed to ensure the implementation of standard or protocol issued by the Director with respect to infection prevention and control.

The Director issued the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes" in April 2022, revised September 2023.

Additional Requirement 9.1 of the IPAC Standard requires the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:
b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident / resident environment contact; before any aseptic procedure;

after body fluid exposure risk, and after resident / resident environment contact);

On two different days during the course of this inspection, several staff members were observed not performing hand hygiene prior entering and exiting a resident home area when the doors to access the unit were closed. The Infection Prevention And Control Lead (IPAC) indicated that the expectation was for staff to perform hand hygiene before entering and before exiting the unit when the door was closed.

Sources: Observation of several staff and interviews with a RN and the IPAC Lead.

2) The licensee has failed to ensure the implementation of standard or protocol issued by the Director with respect to infection prevention and control.

The Director issued the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes" in April 2022.
Additional Requirement 9.1 of the IPAC Standard requires the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:
e) Use of controls, including: i. Environmental controls, including but not limited to, location/placement of residents' equipment, cleaning, making hand hygiene products available.

For three days, a portable hand hygiene sanitizer who was located in front of closed doors to access a unit was not functioning.

Sources: Observations and interviews with the Environmental Services Manager and with the Family Coordinator.

This order must be complied with by October 30, 2024.

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Compliance Order was issued on December 09, 2022 under WS 2022-1364-0002

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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

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.