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

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Public Report

Report Issue Date: January 23, 2025
Inspection Number: 2025-1364-0001
Inspection Type: 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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 20 to 23, 2025

The following intakes were completed in this follow-up inspection:

- Intake #00130779 was Follow-up # 1 to Compliance Order (CO) #001 issued in inspection 2024-1364-0006, related to O. Reg. 246/22 s. 12 (1) 3. with a Compliance Due Date (CDD) of December 13, 2024.
- Intake #00130780 was Follow-up # 2 to CO #002 issued in inspection 2024-1364-0006, related to O. Reg. 246/22 s. 54 (1) with a CDD of December 13, 2024.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intakes #00132780, and #00136008 were related to alleged resident to resident physical abuse.
- Intakes #00134731, and #00135383 were related to alleged resident to resident sexual abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1364-0006 related to O. Reg. 246/22, s. 12 (1) 3.
Order #002 from Inspection #2024-1364-0006 related to O. Reg. 246/22, s. 54 (1)

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 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 to promote zero tolerance of abuse and neglect of residents was complied with for an incident of alleged physical abuse of a resident by a co-resident that occurred on a specified date.

Specifically, a Registered Practical Nurse (RPN) did not comply with the licensee's "Prevention of Abuse and Neglect of a Resident" policy #VII-G-10.00, last revised November 2024. As per the procedure, any team member who witnesses or suspects an incident of abuse of a resident by anyone should "immediately inform the nurse in charge". The RPN acknowledged that the incident was not immediately reported to the evening charge RN and was reported to the Director the following day.

Sources: Critical Incident Report, residents' health records, Prevention of Abuse and Neglect of a Resident policy (#VII-G-10.00) last revised November 2024, and interviews with RPN and ADOC.