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

Public Report

Report Issue Date: June 26, 2025

Inspection Number: 2025-1364-0004

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): June 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 2025

The following intake(s) were inspected:

- Intake: #00140239 - Related to the fall of a resident which resulted in a significant change in health status
- Intake: #00144164 - Related to an enteric outbreak
- Intake: #00145134, #00146259, #00147464, #00147985 and #00147999 - Related to alleged resident to resident sexual abuse
- Intake: #00146907 - Related to alleged resident to resident physical abuse
- Intake: #00146774 - Related to alleged staff to resident physical abuse
- Intake: #00147605 - Related to an environmental hazard
- Intake: #00145199 - Complaint related to infection prevention and control
- Intake: #00145300 - Complaint related to infection prevention and control
- Intake: #00146236 - Complaint related to resident care and services
- Intake: #00147987 - Complaint related to resident equipment and resident care and services

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 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 written plan of care for a resident set out clear directions to staff related to frequency of repositioning and brief changes.

A resident's plan of care was reviewed which included the written care plan and signage posted in the resident's private bedroom. The care plan specified that resident was to be checked, changed and repositioned on first and last rounds during night shifts. The signage posted stated to not change the resident during night shifts unless requested with no specified information related to repositioning.

A Registered Nurse (RN) acknowledged that the current intervention was to check, change the brief and reposition the resident every two hours 24 hours/day as per the Substitute Decision Maker's (SDM) request, which had not been updated in the written plan of care.

Sources: Resident health records; and interviews with an RN and a PSW.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 was provided to a resident as specified in the plan when their bed alarm was not in place.

Sources: Inspector observations, a review of the resident's plan of care and an interview with a PSW.

WRITTEN NOTIFICATION: Plan of care

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 a resident's plan of care related to checking, changing and repositioning every two hours was provided during the night shift of a specific date.

Specifically a Registered Nurse acknowledged that an intervention was started to check, change the brief, and reposition the resident every two hours 24 hours/day as per the resident's Substitute Decision Maker's (SDM) request. Documentation indicated that this intervention was provided to the resident only two times during the night shift. A Personal Support Worker (PSW) acknowledged the nurse verbally informed them of the intervention to attend to the resident every two hours throughout the shift.

Sources: Resident's health records, documentation, unit communication book and interviews with a RN and a PSW.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #004 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 ensure the abuse of a resident by anyone that resulted in harm or a risk of harm to the residents is immediately reported to the Director.

A) On a specific date an incident occurred between two residents. The licensee did not report the incident to the Director until three days later.

B) On a specific date an incident occurred between two residents. The licensee did not report the incident to the Director until two days later.

Sources: Resident health records, Critical Incident Reporting System.

WRITTEN NOTIFICATION: Door in a Home

NC #005 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 to the linen room on a specific unit was kept closed and locked when it was not being supervised by staff.

Sources: Observations and email communication with the Administrator.

WRITTEN NOTIFICATION: Communication and response system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system

s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

A) The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be used by a resident.
On a specific date, the resident informed and demonstrated to the inspector that they were unable to activate their call bell due to their health condition. The administrator of the home was notified and the resident was provided with an alternative option during the course of the inspection.

Sources: Observations and an interview with the resident.

B) The licensee has failed to ensure that the resident-staff communication and response system was easily accessed by a resident at all times, when the cord used to access the system was on the floor and not within their reach.

Sources: Observations and an interview with the resident.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a PSW used safe transferring techniques when they transferred a resident while assisting them with care, which resulted in

injury to the resident. The Associate Director of Care (ADOC) confirmed that the PSW did not follow the residents plan of care related to lifts and transfers.

Sources: Resident's clinical records, complaint letter; home's investigation notes and an interview with the ADOC.

WRITTEN NOTIFICATION: Pain Management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, they were assessed using a clinically appropriate pain assessment instrument. On a specific date, after the resident had a fall post-fall which resulted in injury and pain. When the resident's pain was not relieved by initial interventions, additional pain assessments were not completed.

Sources: A review of the resident's health care record and the Pain and Symptom Management Policy and Procedure (VII-G-30.30), last revised October 2024.

WRITTEN NOTIFICATION: Housekeeping

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (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,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs is cleaned and disinfected using, at a minimum, a low level disinfectant.
During the course of the inspection, the inspector was informed by staff that the disinfectant solution in the bathtub on one of the units was empty. As reported by the staff, despite multiple requests for disinfectant, the product was not provided for approximately three weeks.

Source: Interviews with Personal Support Workers.

WRITTEN NOTIFICATION: Administration of Drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber when a stat, one time dose of pain medication was not administered.

Sources: A review of the resident's health care record and interview with the acting Director of Care.

WRITTEN NOTIFICATION: CMOH and MOH

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all recommendations issued by the Chief Medical Officer of Health were complied with. Specifically, the Ontario Ministry of Health's "Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings", effective February 2025, s. 3.1 IPAC Measures which indicates that Alcohol-based hand rubs (ABHR) must not be expired.

On a specific date, the inspector observed that on a resident unit, two wall dispensers of ABHR were expired.

Sources: Inspector observations and Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings Effective: February 2025

COMPLIANCE ORDER CO #001 Accommodation services

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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;

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

The licensee shall:

A) Develop and implement a cleaning and disinfecting procedure and schedule which includes all resident bedrooms, resident common areas and shared resident equipment.

B) Educate all housekeeping staff on the cleaning and disinfecting procedure and schedule, include the names of staff receiving the education, name of the educator(s) and the dates that the education was provided.

C) Implement a documented audit process to be done every week in one random resident bedroom, one resident common area and one piece of shared resident equipment to ensure the cleaning and disinfecting procedure and schedule are being adhered to.

D) Take immediate corrective action if deviations from the procedure and/or schedule are identified.

E) Maintain a written record of everything required under this compliance order from A-D, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

A) Resident Room

The inspector observed that a resident's bathroom walls were dirty with visible dried matter, the curtains had stains and the lamp shade was accumulated with dust. A housekeeper stated that all resident rooms are to be cleaned daily, including dusting areas in the room and that curtains were to be cleaned annually or as needed. The housekeeper indicated these tasks had not been done in the resident's

room.
The Director of Environmental Services (DES) confirmed there is no documentation to indicate when curtains were last cleaned.

Impact/Risk: Failure to ensure the resident's bedroom is clean and sanitary puts the resident at an increased risk for healthcare associated infections

Sources: Observations made in the resident's room and interviews with a housekeeper and the DES.

B) Washing Machine on Resident Unit
On a specific date a resident informed the inspector that the staff had reported mold in the unit washing machine used to wash the resident's equipment. Upon entering the room that housed the washing machine on on two different dates, the inspector detected a musty smell and noted visible dirt around the inner ledge of the machine and a large amount of dark brown foul smelling matter was found on the inner rubber ring of the machine.
When interviewed, a housekeeper stated they had never been told to clean or disinfect the washing machine on the unit. The Director of Environmental Services (DES) confirmed cleaning/disinfecting the washing machine on the units have not been included in the housekeepers cleaning and disinfecting schedule.

C) Light Fixtures in Heritage Unit Dining Room
On a specific date, a resident informed the inspector that they have been experiencing irritation due to dust in the home. Specifically the resident reported the fixtures in the dining room are covered in dust. Upon inspection of the light fixtures in a unit dining room the inspector noted visible dust on the top of the light fixtures.
When interviewed, the Director of Environmental Services (DES) stated it is the current practice that the maintenance department is responsible for cleaning/dusting the light fixtures in the home and this has not been done due to maintenance workload.

D) Walls and Ceilings on a resident unit.
On two specific dates inspector noted a build up of dust on the wall under and around the blinds and the ceiling tiles in a resident common area.

Impact/Risk: Failure to ensure the resident common areas and resident shared equipment are clean and sanitary puts residents at an increased risk for healthcare associated infections

Sources: Inspector observations, Resident Council meeting minutes, interview with a resident, a housekeeper and the DES.

This order must be complied with by July 31, 2025

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 $1100.00, 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:

In the past 36 months a CO under FLTCA s. 19 (2) b was issued WS 2023-1364-0007

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 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.