Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 12, 2021	2021_593573_0017	007047-21, 008503-21, 008698-21, 009333-21, 009422-21, 009605-21, 010945-21	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Granite Ridge Care Community
5501 Abbott Street East Stittsville ON K2S 2C5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 20 to 22, 26 to 29, 2021 and August 03 to 06, 2021.

The Following logs were completed in this Critical Incident System (CIS) inspection:

(i) Log #009333-21, Log #009422-21, Log #009605-21 and Log #010945-21 were related to resident to resident alleged sexual abuse.

(ii) Log #008503-21 and Log #008698-21 related to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.

(iii) Log #007047-21 regarding a fall incident that caused injury to a resident.

During the course of the inspection, the inspector(s) spoke with the residents, Housekeeping Aide, Personal Support Workers (PSWs), Nursing Rehab Coordinator, Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist, Environmental Services Manager (ESM) , Infection Prevention & Control (IPAC) Lead , Assistant Director of Care (ADOC), Director of Care (DOC) and the Executive Director (ED).

During the course of the inspection, the inspector(s) reviewed the resident health care records, and other pertinent documents. The Inspector(s) observed residents, resident home areas and infection control practices. In addition, inspector(s) observed the provision of care to the resident and observed staff to resident interactions.

Inspector #705004 was also present during this inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for the resident set out clear directions to the staff regarding the resident's wandering behaviours.

A resident's clinical records identified that the resident had responsive behaviors, including the wandering behaviour. The resident's clinical assessment indicated that the wandering behaviour was exhibited by the resident almost everyday. Resident's progress notes documentation indicated multiple incidents in which the resident wandered into other resident rooms.

The resident's plan of care included the focus of responsive behaviors but had not identified the resident's wandering behaviour. Furthermore, no interventions identified for the staff regarding how to respond or manage the resident's wandering behaviors. The lack of clear direction in the resident's plan of care for their responsive behaviours, places potential risk of harm to the residents.

Sources: The resident's plan of care, and interview with the RPN and other staff. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperature of at least two resident bedrooms in different parts of the home and one resident common area on every floor, was measured and documented and that the measured temperature was documented at least once every morning, once every afternoon, and once every evening or night.

On April 1, 2021, memo from Ministry of Long-Term Care to the Long-Term Care Home Stakeholders stated that the amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007 related to enhanced cooling requirements come into force on May 15, 2021.

The Environmental Services Manager (ESM) informed the inspector that the home started to monitor and document the air temperatures as of June 07, 2021. The ESM indicated that the home’s air temperatures were not monitored and documented as per legislated requirements between May 15 and June 07, 2021. There was a potential risk to the residents comfort and safety as air temperatures were not monitored and documented between May 15 and June 07, 2021.

Sources: LTCH's Air temperature documentation records and interview with the ESM. [s. 21. (3)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident had occurred shall immediately report the suspicion and the information upon which it is based to the Director.

A resident's clinical records identified that the resident had responsive behaviors, including the sexual behaviours. The resident's progress note documentation by the RPN indicated that a PSW reported resident's inappropriate touching behaviour towards another resident. Interview with the DOC confirmed that both the residents do not have the capacity to consent to any sexual activity. Furthermore, the DOC indicated that the RPN failed to report the incident to their supervisor and to the Ministry of Long-Term Care. Failure to report all suspected allegations of the residents abuse, places potential risk of harm to the residents.

Sources: Residents clinical record and interview with the DOC. [s. 24. (1)]

Issued on this 30th day of August, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.