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

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Original Public Report

Report Issue Date July 27, 2022
Inspection Number 2022_1364_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Royale Development GP Corporation as general partner of The Royale Development LP

Long-Term Care Home and City
Granite Ridge Care Community, Stittsville

Lead Inspector
Gurpreet Gill (705004)

Inspector Digital Signature
Gurpreet K Gill
Digitally signed by Gurpreet K Gill
Date: 2022.08.25 09:44:20 -04'00'

Additional Inspector(s)
Megan MacPhail (551); Karen Buness (720483)

Severn Brown (740785); Sarabjit Kaur (740864); Laurie Marshall (742466); Erica McFadyen (740804) were also present during this inspection

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 17-20, 25-27, 30, 31, June 1-3, 6 and 7, 2022

The following intake(s) were inspected:

- Intake:003488-22 Complaint related to provision of care and services including communication with the family
- Intake: 008391-22 Complaint related to mechanical lift training/education
- Intake: 002069-22 Complaint related to allegations of staff to resident abuse
- Intake: 001440-22 Complaint related to the management of blood sugar
- Intake: 006926-22 Critical Incident (CI) # 2879-000026-22 related to alleged resident to resident sexual abuse
- Intake: 006057-22 CI #2879-000023-22 related to alleged resident to resident physical abuse
- Intake: 005932-22 CI # 2879-000022-22 related to alleged resident to resident physical abuse

- Intake: 000575-22 CI # 2879-000002-22 related to alleged resident to resident physical abuse
- Intake: 004009-22 CI #2879-000014-22 related to a fall incident that caused injury to a resident
- Intake: 002517-22 CI #2879-000007-22 related to a fall incident that caused injury to a resident
- Intake: 002369-22 CI# 2879-000006-22 related to a fall incident that caused injury to a resident
- Intake: 017738-21 CI #2879-000048-21 related to a fall incident that caused injury to a resident
- Intake: 002052-22 CI # 2879-000004-22 related to an injury that caused a change in health status
- Intake: 015683-21 CI # 2879-000041-21 related to an injury during a transfer
- Intake: 017828-21 CI #2879-000048-21 related to dehydration and high blood sugar level
- Intake: 001515-22 Follow up to compliance order (CO) #001 issued on Jan 10, 2022 (amended on Feb 17, 2022) under inspection report # 2021_627004_0004 related to the Long-term care Act (LTCHA), s. 6 (7) (Plan of Care) with a compliance due date of March 04, 2022

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 6(7)	2021_627004_0004	#001	Gurpreet Gill (705004)

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services
- Responsive Behaviours
- Safe and Secure Home
- Staffing, Training and Care Standards

INSPECTION RESULTS

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program, specifically related to the use of personal protective equipment (PPE).

Rationale and Summary

On a day in May 2022, the inspector observed that two residents were identified to be in isolation. Both residents were on droplet and contact precautions as per the sign on their bedroom door. Staff were required to wear full PPE including mask, eye protection, gown, and gloves for all interactions. The inspector observed that two Personal Support Workers (PSWs) exited the residents' room, who required droplet and contact precautions. One PSW was wearing a mask and gloves but no gown or eye protection when they exited the room and carried soiled laundry and pushed the clean cart with incontinent products down the hall with the same gloves. Another PSW was wearing a mask, gown and gloves and no eye protection when they exited the room and started untying their gown with same gloves.

A PSW indicated that they had not used all of the required PPE when they provided direct care to both residents.

Failing to participate in the implementation of the IPAC program increases the risk of disease transmission among residents and staff when the resident is required to be in isolation.

Sources: Interview with identified staff member and observations made by the inspector. []705004]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Diabetes Management – Hypoglycemia policy (VIII-C-10.30) stated that the nurse will:

1) Obtain capillary blood glucose reading when a resident exhibits the symptoms of hypoglycemia and/or as ordered by the Physician/NP.
2) Promptly treat conscious or unconscious diabetic residents who may or may not be exhibiting known signs of hypoglycemia and/or whose blood glucose readings are below 4 mmol/L and/or as per Physician/NP orders.

Appendix B directed that the care of the conscious resident who is experiencing mild to moderate hypoglycemia, under 4.0mmol/l and above 2.9mmol/L to: treat with 15 grams of carbohydrate in the form of 4 glucose tablets or 1 tablespoon of honey or 3 sugar packets

dissolved in water or ¾ cup apple juice. Recheck after 15 minutes, and if blood glucose remains less than 4 mmol/L, repeat treatment with 15 grams of carbohydrate. The policy directed that: Once blood glucose has returned to above or equal to 4.0 mmol/L, ensure resident has the usual meal or snack that is due at the time of day. The resident was ordered a combination of diabetes medications, and their blood glucose was checked four times daily. Between the specified dates in May 2022, the resident had eight blood glucose readings that were below 4.0mmol/L at 1630/1700 hours. On two of the days in May 2022, the resident's blood glucose was 3.3 and 3.6, respectively at 1630/1700 hours. An RPN stated no treatment for hypoglycemia was administered as the resident would have been eating supper. As per the RPN after 1630/1700 hours, the resident's blood glucose was checked next at 2100 hours. Failure to follow the hypoglycemia policy by using an intervention that provides a rapid rise in blood glucose to a safe level could lead to complications of hypoglycemia. **Sources:** The resident's health care record, Diabetes Management – Hypoglycemia policy (VIII-C-10.30 and b) and interview with an RPN. [551]	

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 76 (1) for failing to ensure that all staff in the home have received training as required by this section. LTCHA, 2007, s. 76 (2) (11) stated that every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 11. Any other areas provided for in the regulations. O. Reg 79/10, s. 218 stated that for the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided: 2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities. LTCHA, 2007, s. 76 (4) stated that every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or intervals provided for in the regulations.	

O. Reg 79/10, s. 219 stated that the intervals for the purpose of subsection 76 (4) of the Act are annual intervals.

Rationale and Summary

The resident was transferred with the assistance of two staff. On a day in August 2021, the resident was unable to safely weight bear and was transferred with the use of a mechanical lift as needed. On a day in August 2021, the resident was assessed by the physiotherapist, and their transfer status was changed to a mechanical lift for all transfers.

Three different PSWs worked day, evening and night shift on the days in question in August 2021.

As per an RPN who is the home's designated lead for the training and orientation program, the PSWs last received training on the safe and correct use of equipment, including mechanical lifts in 2019.

Failure to provide annual training on the safe and correct use of mechanical lifts meant that staff were not up to date with their training as required by the legislation and could lead to the incorrect use of equipment when transferring a resident.

Sources: The resident's health care record and interview with an RPN. [551]

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s.6 (5)

The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Rationale and Summary

On a day in February 2022, the home contacted the resident's Substitute Decision-Maker (SDM) to inform that the resident's tilt wheelchair had been adjusted by the physiotherapy department. At time of the call, the SDM stated that they were unaware that the resident was in a wheelchair and requested information as to why the wheelchair was needed and when the wheelchair was provided.

A review of the resident's progress notes revealed that the resident was provided a wheelchair to ambulate in a month prior to February 2022, due to a decline in health condition. An RPN

verified the resident uses a tilt wheelchair to ambulate and stated it is the expectation that staff notify the SDM if there is a change in condition.

The Director of Care (DOC) admitted a mistake had been made and that it was the home's regular practice to notify SDMs when there is a change in the resident's condition.

The impact of the home's failure to ensure the resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care led to a complaint being lodged against the home voicing concern about the home's lack of communication and not providing the SDM and family the opportunity to contribute to the resident's plan of care.

Sources: The resident's health care record, interviews with an RPN and the Director of Care, telephone interview with complainant. [720483]

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