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: October 26, 2023

Inspection Number: 2023-1364-0007

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

Lead Inspector	**Inspector Digital Signature**
Martin Orr (000747)	Martin Orr Digitally signed by Martin Orr Date: 2023.11.06 14:24:11 -05'00'

Additional Inspector(s)
Lisa Cummings (756)

INSPECTION SUMMARY

This inspection occurred on-site on the following dates: September 5, 6, 7, 8, 11, 12, 14, 18, 20, 25, 27, 28, 29, 2023.

The following intakes were inspected during this complaint inspection;

Intake: #00094176 complaint related to resident-to-resident alleged abuse.
Intake: #00094688 complaint related to cleanliness of home and pest control.

The following intakes were inspected during this Critical Incident (CI) Inspection:

Intake: #00096258-CI:2879-000044-23 related to fall with injury resulting in a significant change in condition
Intake: #00093819-CI:2879-000040-23-related to resident-to-resident alleged abuse.
Intake: #00093739-CI: 2879-000037-23-related to staff to resident alleged abuse.
Intake: #00093145-CI: 2879-000035-23-related to staff to resident alleged abuse.
Intake: #00093812-CI:2879-000039-23 related to resident-to-resident alleged abuse.

The following intakes were completed during in this inspection:

Intake: #00092604-CI: 2879-000033-23-related to fall with injury resulting in a significant change in condition.
Intake: #00094756-CI: 2879-000041-23 related to fall with injury. resulting in a significant change in condition.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
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)

The licensee has failed to ensure that the homes policy on the Prevention of Abuse and Neglect of a Resident was complied with.

Rationale and Summary:
The homes policy on the Prevention of Abuse and Neglect of a Resident states that that all staff and volunteers must immediately report any suspected abuse to the charge nurse.

A progress note on a resident states that the resident had bruising and told the writer of the note an RPN that a staff member caused the bruising. The progress note also states the charge nurse RN was

notified. In an interview with the RN they confirmed being the charge nurse and also confirmed they were not notified of possible staff to resident abuse by the RPN. The RN indicated they only learned of the resident injury, a few days later.

The failure to follow the homes policy on the the Prevention of Abuse and Neglect with a staff member not reporting to the charge nurse.

Sources:
Resident progress note, Interviews with the RN, and the homes policy on the Prevention of Abuse and Neglect of a Resident.
[000747]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that the door to the servery on a resident home area was locked.

Rationale and Summary
The Inspector observed the door to the servery on a resident home area to be unlocked. The keypad on the door was not functional and the door could be opened without a code. Further, the double door to the dining room on the same resident home area was unlocked which provided access to the servery area.

A Dietary Aide stated the keypad lock to the servery on this resident home area and the lock on the door to the dining room were both broken. The Dietary Aide identified that the servery was a non-resident area and the residents should not have access to it.

Failing to ensure the door to the servery was locked was a potential risk of harm to residents.

Sources: Observations of a dining room and servery, interviews with a Dietary Aide and Environmental Services Manager.

[756]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that three staff members used safe techniques when transferring a resident from the bed to a chair.

Rationale and Summary:
A PSW #115 was observed performing a one-person pivot lift on a resident. PSW #115 confirmed in an interview with the Inspector that they performed a one-person lift. PSW #116 and #118 were observed performing a two-person side by side transfer on the same resident. The current plan of care states that the resident is a two-person transfer using the mechanical lift.

By not ensuring proper transfer techniques were followed as per the plan care the resident was placed at increased risk of injury.

Sources:
Interviews with a PSW and other staff, video clips, and the residents plan of care.
[000747]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that a reassessment was completed for a resident exhibiting responsive behaviours.

Rationale and Summary
A resident was on behaviour monitoring and progress notes identified that the resident exhibited responsive behaviours. The first progress note stated that the resident tapped a family member after they greeted the resident. A further progress note stated the resident pushed another resident seated in their wheelchair away from them and down a hallway. The co-resident was described as moving quickly down the hallway but was not injured from this incident. Although the resident continued on behaviour monitoring following these incidents, a reassessment of their responsive behaviours towards co-residents and visitors was not completed.

An RPN and an RN stated the resident mostly stayed in their room alone and did not interact with other residents. The RN stated the resident's responsive behaviours had increased over the previous months and that responsive behaviours towards other residents would be a new behaviour.

An ADOC stated they were not made aware of the incidents from the specified shift. They stated the incident of the resident pushing a co-resident in their wheelchair should have been investigated.

Failing the reassess resident following the incidents created a potential risk to other residents.

Sources: Progress Notes; interview with an RPN , an RN , and the ADOC .

[756]

WRITTEN NOTIFICATION: Pest Control

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 94 (2)

The licensee failed to take immediate action to deal with a rodent infestation.

Rationale and Summary
Rodent droppings were observed in the servery areas of four resident home areas. Dietary Aides acknowledged that they had recently observed rodent droppings in servery areas, as well as sightings of mice. Further, a Cook and the Director of Dietary Services advised that mice in the building was a yearly occurrence, however the issue was worse this year than previous years. The Cook stated the mice were in the walls and dietary staff had observed mice on all three floors of the building.

The Director of Environmental Services stated they were not aware of mouse sightings or rodent droppings in servery areas, however they acknowledged there was a mouse infestation in the building. During this interview, the Director of Environmental Services was shown photographs of the rodent droppings in the four serveries and in response stated they would have the areas deep cleaned. However, upon observation three days later, the four serveries had not been cleaned and the rodent droppings remained. The Director of Environmental Services stated the housekeeping department was short staff and they were not yet able to schedule the deep clean of the servery areas. Further, the licensed pest controller was not able to come to the home until a later date.

Failing to immediately address the mouse infestation created an opportunity for the infestation to

proliferate and increased the risk of illness to residents.

Sources: Observations; Interviews with Dietary Aides, a Cook, the Director of Dietary Services, and the Director of Environmental Services.

[756]

WRITTEN NOTIFICATION: Maintenance Services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)

The licensee has failed to ensure there were schedules and procedures in place for routine, preventative and remedial maintenance of the resident-staff communication and response system (RSCRS).

Rationale and Summary
A resident identified that their call bell occasionally seemed broken. Further, during a night shift the resident's RSCRS was not functioning and a staff member remained seated outside of the resident's room to provide assistance.

The Director of Environmental Services confirmed that in the past the residents RSCRS had been broken and unreliable. The Director of Environmental Services was not aware that the RSCRS was not functioning during a certain night shift in September 2023, as a maintenance request was not submitted.

The Director of Environmental Services provided the policy Risk Management Plan – Maintenance and identified this as the maintenance schedule they followed. The RSCRS was not included in this maintenance schedule. They stated they were not able to identify any other written schedule or procedure that spoke to the routine, preventative and remedial maintenance of the RSCRS.

The Director of Environmental Services stated they complete a yearly audit of the RSCRS with a contracted company. They stated they did not complete any other routine or preventative maintenance of the system despite identifying that the RSCRS had been unreliable for this resident.

Failing to have schedules and procedures for routine, preventative and remedial maintenance of the RSCRS posed a potential risk of reliability issues with the system.

Sources: Progress Notes; Risk Management Plan – Maintenance; interviews with resident and the

Director of Environmental Services.

[756]

COMPLIANCE ORDER CO #001 Accommodation Services - Cleanliness and Repair

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)

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

1) Immediately complete an observation of all areas in all of the serveries on each resident home area (RHA) and identify if rodent droppings are present.

2) Immediately clean and disinfect all areas of the servery on the four specified resident home areas, and any other resident home area where rodent droppings were identified in step (1). This must include cleaning all surfaces, inside drawers and cupboards, cutlery, serving utensils and any other items stored in the drawers and cupboards, and equipment.

3) Develop a routine for cleaning and disinfecting the servery areas that ensures when rodent droppings are observed, that the rodent droppings, the area the rodent dropping is observed, and all equipment and supplies in that identified area, are cleaned and disinfected prior to each meal service.

4) Develop and implement monitoring and remedial processes as follows:

a) Develop and complete daily audits to ensure compliance with the developed routine for cleaning and disinfection as referenced above. The daily audit will be completed for the serveries of the four specified resident home areas, and any other servery where rodent droppings were identified in step (1), until there is documented confirmation that the rodent infestation is resolved.
b) The licensee shall ensure that relevant corrective action is taken if deviations from the established cleaning and disinfection routine are identified.

A written record must be kept of everything required under steps (1), (2), (3), and (4) of the compliance order, 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 and equipment in the home were kept clean and sanitary.

Rationale and Summary
A Dietary Aide identified rodent droppings in the servery area of a resident home area (RHA). There were rodent droppings present in the servery area in multiple drawers and cupboards, including areas that stored serving utensils and mugs, as well as in the dishwashing area, including on top of the dishwasher and on the rolling rack that stored the dish racks. On the same day, rodent droppings were observed in a second servery area on another RHA. with rodent droppings observed in drawers that stored serving utensils and in cupboards; and in a servery of a third RHA with rodent droppings found in the cupboard that stored cereal containers and a drawer that stored serving utensils. Rodent droppings were observed on a fourth RHA servery the following day, with the rodent droppings observed in two drawers that stored serving utensils and in a cupboard that stored serving trays.

Dietary Aides acknowledged they had recently observed rodent droppings in severy areas. A Dietary Aide stated they would clean the servery area once a week, however they acknowledged that there were still rodent droppings present at the time of the interview.

The Director of Dietary Services stated that dietary staff are responsible for cleaning the servery areas and that staff should be cleaning rodent droppings as soon as they observe this. They stated this direction had been in place prior to September 2023.

Failing to keep the servery areas clean and sanitary placed residents at risk of illness.

Sources: Observations of four resident home areas; interviews with Dietary Aides and the Director of Dietary Services.

[756]

This order must be complied with by November 22, 2023

COMPLIANCE ORDER CO #002 Pest Control

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 94 (1)

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

1) Develop and implement an action plan in collaboration with the licensed pest controller to address the current rodent infestation in the home.

2) Develop and implement a procedure for all staff to follow to report and document pest sightings and any evidence of pests, such as rodent droppings. The documented information shall be reviewed daily by the Director of Environmental Services, or designate, and immediate action shall be taken in response to these reports.

3) Provide all staff with education on the licensee's procedure for reporting pest sightings and any evidence of pests, such as rodent droppings.

4) Ensure that site visit reports from the licensed pest controller are available onsite following each site visit. The Director of Environmental Services, or designate, shall review the site visit reports and, as necessary, take follow-up corrective actions immediately.

5) Develop and complete a weekly pest control assessment audit to assess the presence of pests, including flies and rodents, in the home and monitor outcomes of the implemented action plan. The weekly audit will be completed on all resident home areas until there is documented confirmation that the rodent infestation has resolved, and then monthly thereafter as per the pest control prevention and management policy. Corrective actions will be taken immediately if new issues with pests are identified or if the action plan for a current pests infestation is found to be ineffective.

A written record must be kept of everything required under steps (1), (2), (3), (4), and (5) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied this order.

Grounds
1) The licensee has failed to ensure the preventative pest control program was complied with.

Rationale and Summary
In accordance with Ontario Regulation (O. Reg.) 246/22 s. 94 (1), the licensee shall ensure there is a preventative pest control program in place, and in accordance with O. Reg. 246/22 s. 11 (1) (b), the program shall be complied with.

Specifically, the licensee failed to comply with the following sections of Pest Control Prevention and

Management policy:

i. The Pest Control Log Book;
ii. The licensed pest controller's site visit reports were to be reviewed and follow-up on recommended corrective actions were to be taken immediately;
iii. Monthly pest control assessment audits.

The Director of Environmental Services confirmed that the Pest Control Prevention and Management policy was a part of the pest control program. However, they identified they had not read the policy prior to the interview and did not have in place all responsibilities identified in the policy.

i. The pest control policy stated there was to be a Pest Control Log Book in place for reporting issues with pests. The policy continued to state that any sightings of pests that were submitted electronically were to be logged in the Log Book, and the Log Book was to be monitored daily and actions were to be taken as required.

The Director of Environmental Services stated they did not have a Pest Control Log Book in place. They stated they received reports of issues of pests through their online maintenance record (Maintenance Care), through email, and through phone calls and voicemail messages. They did not keep a record of these reports in one location and could not provide a record of the reports of pest sightings received through email, phone call, and voicemail.

Specifically, the online maintenance request system had two pest sightings reported over the two-month period. The Director of Environmental Services stated they had received additional reports of mouse sightings over that time period but could not provide the details of these reports or a record of these reports.

ii. The pest control prevention and management policy stated that the licensed pest controller site visit reports were to be reviewed and a follow-up on recommended corrective actions were to be taken immediately. The Director of Environmental Services identified they had not been provided with all records of service from the licensed pest controller.

A review of the pest control service records from a 2-month period was conducted. The first licensed pest controller site visit reviewed did not specify what actions were taken during the visit; and the second site visit reviewed identified all areas of the home had been skipped. The Director of Environmental Services identified they had not reviewed these reports and did not know what actions had been taken in regard to pest control for the two site visits.

iii. The pest control prevention and management policy listing the monthly pest control assessment audit as a responsibility of the Director of Environmental Services. The Director of Environmental Services stated they thought the licensed pest controller might be responsible for completing the monthly audit. However, the Director of Environmental Services later clarified they had reviewed the licensee's pest control policy and that the monthly pest control assessment audits was their responsibility to complete. They identified that they had not been completing a monthly audit and did not have an audit tool to do this.

Failing to comply with the pest control prevention and management policy created a risk of a pest infestation to proliferate in the home.

Sources: Pest Control Prevention and Management policy; Orkin service repots; interviews with the Director of Environmental Services .

[756]

2) The licensee has failed to ensure that the pest control program provided methods to monitor outcomes for the flies identified in a resident's room.

Rationale and Summary
In accordance with Ontario Regulation (O. Reg.) 246/22 s. 94 (1), the licensee shall ensure there is a preventative pest control program in place, and in accordance with O. Reg. 246/22 s. 34 (1) 1. the program shall provide for methods to monitor outcomes.

The Pest Control Prevention and Management policy stated that the Director of Environmental Services would maintain a record of service reports and action plans.

The resident room was observed to have multiple fly trap hung from the ceiling in their room, and four of the fly traps had dead flies present. A Maintenance Worker stated that they were aware of the fly traps in the resident room and they, or a housekeeper, would change the fly traps when the resident's Substitute Decision Maker (SDM) requested that this be completed. However, a Housekeeper identified they regularly worked on resident home area and did not know who was responsible for the fly traps or where extra fly traps were kept.

Further, the Director of Environmental Services stated they had not contacted a licensed pest controller this year regarding the flies in resident room and had not created an action plan to monitor or change the fly traps. The Director of Environmental Services stated they first became aware of the issue of flies in the resident room and installed fly traps the same day. They stated that when the fly traps were

observed during the inspection, it would had been several weeks since the traps had been changed despite multiple dead flies present on the traps.

Failing to provide for methods to monitor outcomes caused the traps hung from the resident's ceiling, with dead flies present, to remain in place for several weeks.

Sources: Observations of resident room; Pest Control Prevention and Management Policy; Interviews with Maintenance Worker , Housekeeper and the Director of Environmental Services .

[756]

This order must be complied with by November 22, 2023

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.