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 30, 2024
Inspection Number: 2024-1364-0006
Inspection Type: Complaint 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 date(s): October 7, 8, 9, 10, 11, 15, 16, 17, 18, 21, 22, 23, 24, 25 2024.
The inspection occurred offsite on the following date(s): October 10, 2024

The following intakes were completed in this Critical Incident (CI) inspection: Intake #00121217/CI#2879-000073-24, Intake #00121217/CI # 2879-000073-24, Intake #00121898/CI #2879-000076-24, Intake #00126110/CI #2879-000098-24- related to a fall that resulted in a significant change requiring a transfer to hospital,

Intake #00122122/ CI #2879-000078-24, Intake #00122679/CI#2879-000079-24, Intake #00122952/ CI#2879-000081-24, Intake #00122976/ CI #2879-000082-24, Intake #00125954/CI#2879-000097-24, Intake:#00126935/ CI#2879-000101-24,
Intake #00127372/CI#2879-000105-24 related to allegations of abuse

Intake#00122067/ CI#2879-000077-24 related to allegation of neglect of care

The following intakes were completed during this Complaint Inspection:
Intake #00121835 related to housekeeping and laundry, Intake #00129458 related to allegations of abuse, and safe and secure home , Intake: #00123653, Intake: #00128045 related to allegations of neglect and abuse.

The following intake was completed in this Follow up inspection:
Intake: #00118402 - Follow-up #: 1 - O. Reg. 246/22 - s. 93 (2) (a) (i)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1364-0003 related to O. Reg. 246/22, s. 93 (2) (a) (i)

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry, and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
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 a written plan of care was set out providing clear directions to staff and others who provide direct care for a specific resident for a specific care need.

Sources: CI #2879-000105-24, CI #2879-000106-24, observations, resident's clinical records.

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

On several days during a specific month, the licensee failed to ensure that specific care documentation was completed for a specific resident.

Sources: Record review and interviews with three specific staff .

WRITTEN NOTIFICATION: General Requirements for Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that monitoring of resident #010 post fall was documented.

O. Reg. 246 / 22, s. 54 (1) requires that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents and O. Reg. 246 / 22, s. 34 (2) requires that the licensee shall ensure that any actions taken with respect to a resident under a program, be documented.

A specific staff explained that after a resident has fallen, staff are expected to monitor the resident every shift using the Q Shift 72 Hour Post Fall Assessment. A specific resident experienced a fall on a specific shift. There was no documented assessment completed on the specific shift. As a result, there was risk to the resident's health as the health care record was incomplete.

Sources: the Resident's electronic health care record, interview with two staff members.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds is reassessed at least weekly by an authorized person. For a specific resident a weekly assessment of skin impairments was not completed during a specific week for one specific area of altered skin integrity. For the resident a second specific area of altered skin integrity there was no weekly assessments completed during a specific month.

Sources: A specific resident's clinical record, interview with two specific staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that behavioural monitoring tools are completed

on each shift following initiation of the protocol in response to a new treatment or following a critical incident for residents three specific residents.

1. Two specific staff members indicated the expectation is that documentation is completed each shift during the period when the behavioural monitoring protocol is in place. During a review of the Behaviour Support Ontario-Dementia Observation System (BSO-DOS) tool it was found documentation was missing for multiple shifts during specific observation periods for a specific resident.

Sources: Behaviour Support Ontario-Dementia Observation System (BSO-DOS) worksheets, Responsive Behaviours Management (policy #VII-F-10.10, revised August 2024), Interviews with two specific staff

2. Two specific staff members indicated the expectation is that documentation is completed each shift during the period when the behavioural monitoring protocol is in place. During a review of the Behaviour Support Ontario-Dementia Observation System (BSO-DOS) tool it was found documentation was missing for multiple shifts during specific observation periods for a specific resident.

Sources: Behaviour Support Ontario-Dementia Observation System (BSO-DOS) worksheets, Responsive Behaviours Management (policy #VII-F-10.10, revised August 2024), Interview with staff with two specific staff.

3. Two specific staff members indicated the expectation is that documentation is completed each shift during the period when the behavioural monitoring protocol is in place. During a review of the Behaviour Support Ontario-Dementia Observation System (BSO-DOS) tool it was found documentation was missing for multiple shifts during specific observation periods for a specific resident.

Sources: Behaviour Support Ontario-Dementia Observation System (BSO-DOS) worksheets, Responsive Behaviours Management (policy #VII-F-10.10, revised August 2024), Interviews with two specific staff.

COMPLIANCE ORDER CO #001 Doors in a home

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
A) Educate all staff in all departments about the legislative requirement under O. Reg. 246 / 22 s. 12 (1) 3. of ensuring that all doors leading to non-residential areas must be kept closed and locked when they are not directly supervised by staff, and on their formal roles and responsibilities in always ensuring compliance with this provision.

B) Maintain a documented record that includes the content of the education provided, the date of the education, name and designation of staff educated, and who provided the education.

C) Develop and implement daily audits for two weeks, including on weekends and holidays to ensure that doors leading to non-residential areas are kept closed and

locked (unless being directly supervised by staff). Audits to include a sampling from different shifts. Doors leading to three specific non-residential areas to be audited.

Following the initial two week audit cycle, audit frequency to be decreased to weekly, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

D) Take immediate corrective action if doors leading to specified non-residential areas are found to be unlocked and not directly supervised by staff, which includes following up with staff who have the responsibility to lock the door(s).

F) Maintain a written record of all audits and corrective actions taken including the date, time, name and signature of the staff member conducting the audits.

Grounds
The licensee has failed to ensure doors leading to non-residential areas are kept closed and locked to restrict access by a resident to those areas when not being supervised by staff.

A Ministry of Long-Term Care Inspector observed doors leading to specific non-residential areas were found to be unlocked and not directly supervised by staff on specific dates.

During an interview with a specific staff, they indicated the specific areas on each resident unit are not considered resident spaces, and the door should have been closed and locked when not in use by staff.
A record review of an incident reported on a specific date for a specific resident indicated the resident experienced an unwitnessed fall in an unlocked storage room on a specific resident unit. During an interview with two specific staff, they indicated the specific room was not a resident space and the door should have been closed

and locked.

Sources: Incident report for a specific date, interview with three specific staff observation by a Ministry of Long-Term Care, Inspector

This order must be complied with by December 13, 2024

COMPLIANCE ORDER CO #002 Falls prevention and management

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246 / 22, s. 54 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:
A) Educate three specific staff members on the Falls Prevention and Management, V11-G-30.10 policy and procedure, last revised 06 / 2024.

B) Maintain a documented record that includes the content of the education provided, the date of the education, name and designation of staff educated, and who provided the education.

C) Develop and implement audits for all residents that require initiation and completion of the Head Injury Routine (HIR) as outlined in Policy and Procedure-V11-G-30.10: Falls Prevention and Management (rev 06/2024). Audits to be completed weekly until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

D) Provide immediate education to staff that have not initiated and completed the Head Injury Routine (HIR) as outlined in Policy and Procedure-V11-G-30.10: Falls Prevention and Management (rev 06/2024).

F) Maintain a written record of all audits and corrective actions taken including the date, time, name and signature of the staff member conducting the audits.

Grounds

The Licensee has failed to ensure that the home's falls prevention and management program was followed, specifically that a head injury routine (HIR) be completed on three specific residents, after an unwitnessed fall.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes the monitoring of residents, and that it must be complied with.

1) As per the home's Falls Prevention and Management Policy, a HIR is to be initiated for all unwitnessed falls. A specific resident experienced an unwitnessed fall, and no HIR was initiated. There was risk of harm to the resident by not monitoring for a change in health condition after the resident's fall.

Sources: Falls Prevention and Management, V11-G-30.10 policy and procedure, last revised 06/2024, specific resident's records, interview with three specific staff.

2) During an interview a specific staff member stated the nurses are required to initiate a head injury routine assessment for all residents that sustain an unwitnessed fall, or a fall that results in a head injury. The specific staff member indicated after a review of a specific resident's records they were unable to locate HIR document for the unwitnessed fall the resident sustained on a specific date.

Sources: Interviews with three specific staff members, Policy #VII-G-30.10-Falls Prevention and Management Program (revised 6/24), specific resident's records.

3) The Head Injury Routine (HIR) document for a specific resident was initiated after an unwitnessed fall on a specific date. A record review of the HIR document reflected the HIR assessment was not completed at the required scheduled times for the resident.

Sources: Interviews with three specific staff, Policy #VII-G-30.10-Falls Prevention and Management Program (revised 6/24), Head Injury Routine (HIR) form for the resident.

This order must be complied with by December 13, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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

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.