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

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Public Report

Report Issue Date: December 20, 2024
Inspection Number: 2024-1364-0007
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 dates: December 3-6, 2024, December 9-13, 2024, and December 16-20, 2024.

The following intake was completed in this follow-up inspection:

- Intake #00123993 was Follow-up # 1 to Compliance Order (CO) #001 issued in inspection 2024-1364-0004, related to O. Reg. 246/22 s. 102 (2) (b) with a Compliance Due Date (CDD) of October 30, 2024.

The following intakes were completed in this complaint inspection:

- Intake #00130057 was related to concerns regarding alleged neglect of a resident.
- Intake #00132520 was related to concerns regarding alleged abuse and the care of a resident.
- Intake #00132921 was related to concerns regarding air temperatures, laundry services and dining services.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00129586 was related to alleged staff to resident abuse.
- Intakes #00130628, #00131109, #00131564, were related to alleged resident to resident physical abuse.
- Intakes #00132377, #00132518, #00133338 were related to alleged resident to resident sexual abuse.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1364-0004 related to O. Reg. 246/22, s. 102 (2) (b)

The following Inspection Protocols were used during this inspection:

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 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 of completing Head Injury Routine (HIR) assessments, as set out in the plan of care was provided to a resident, as specified in the plan of care.

Specifically, the licensee has failed to ensure that the 72 hours head injury routine assessments were completed during the four hour periods that required hourly assessments on a specified date and on a specified shift of a specified date as confirmed by Assistant Director of Care (ADOC).

Source: A resident's health records, head injury monitoring record, interview with Registered Nurse (RN) and ADOC.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to

promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

Specifically, a staff member did not comply with the licensee's "Prevention of Abuse and Neglect of a Resident" policy (#VII-G-10.00), last reviewed November 2024. As per the procedure, any team member who witnesses or suspects an incident of abuse of a resident by anyone should "immediately inform the nurse in charge". The staff member stated they did not immediately report an alleged incident of staff to resident abuse until approximately one week later.

Sources: A resident's health records, Critical Incident Report, internal investigation notes, and interviews with a staff member and Office Manager.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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.

A) The licensee has failed to ensure that an alleged incident of resident neglect was immediately reported to the director. Specifically, the licensee has failed to

immediately report an alleged incident of neglect, to a resident that occurred on a specified date, which was confirmed by an ADOC that it was never reported to the Director.

Sources: review of the Ontario LTC homes Portal and interview with ADOC.

B) The licensee has failed to ensure that an alleged incident of resident abuse was immediately reported to the director. Specifically, the licensee has failed to immediately report an alleged incident of abuse to a resident, that occurred on a specified date, as confirmed by an ADOC it was reported late to the Director.

Sources: review of Critical Incident Report, interview with ADOC.

C) The licensee has failed to ensure that a suspected incident of alleged resident sexual abuse was immediately reported to the director. Specifically, the licensee has failed to immediately report a suspected incident of alleged sexual abuse of a resident. The incident occurred on a specified date and was reported two days later.

Sources: Critical Incident Report, Interview with Registered Practical Nurse (RPN), Behavior Support Ontario (BSO) and ADOC.

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) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours,

where possible; and

The licensee has failed to ensure that the strategies for managing the responsive behaviours of a resident were implemented during a bath on a specified date. Specifically, a specified behavioural strategy identified in the resident's plan of care was not utilized when the resident started to exhibit responsive behaviours towards staff during the bath. A Personal Support Worker (PSW) stated that they continued with the bath despite the resident exhibiting these behaviours. BSO acknowledged that the behavioural strategy in the resident's plan of care should have been followed by staff.

Sources: A resident's health records, and interviews with PSWs and BSO.

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.

A) The licensee has failed to ensure that when a resident demonstrated responsive behaviours, the Behaviour Support Ontario - Dementia Observation System (BSO - DOS) mapping tool that was initiated was analyzed in the reassessments of the resident.

Sources: A resident's health records, BSO-DOS worksheet, interview with BSO and ADOC.

B) The licensee has failed to ensure when a resident demonstrated responsive behaviours during an altercation with another co-resident, that the information collected in BSO-DOS mapping tool that was initiated was analyzed as part of the reassessment of the resident.

Sources: A resident's health records, BSO-DOS worksheet, and interview with BSO.

C) The licensee has failed to ensure when a different resident demonstrated responsive behaviours during an altercation with another co-resident, that the information collected in BSO-DOS mapping tool that was initiated was analyzed as part of the reassessment of the resident.

Sources: A resident's health records, BSO-DOS worksheet, and interview with BSO.

D) The licensee has failed to ensure that when two residents demonstrated responsive behaviours, the BSO-DOS mapping tools that were initiated were analyzed in the reassessments of the residents.

Sources: Residents' health records, and interviews with RPN and ADOC.

WRITTEN NOTIFICATION: Dining and snack service

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that a resident's soup was being served at a temperature that was safe and palatable. The resident was served a soup that the initial temperature before service was 173 Fahrenheit (F) and by the time a PSW provided assistance, the soup temperature was 120 F. The resident had indicated that if assistance is not provided when they are served, the soup can be cold.

Sources: Interviews with a resident, PSW and temperature records.

WRITTEN NOTIFICATION: Laundry service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 95 (1) (b)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;

The licensee has failed to ensure that there is sufficient supply of facecloths and bath towels that are always available in the home for residents' use. Two PSWs indicated that they are frequently short of towels and have to go on other units or to the laundry room to get extra towels to provide care to the residents. The Director of Environmental Services indicated that they have done an audit in a specified month, which reflected a shortage in towels. At that time, extra towels were ordered but as of December 6, 2024, these towels were not yet delivered to the home as they

were back ordered.

Sources: Interviews with PSWs, Laundry Staff and Director of Environmental Services.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that a medication cart was secured and locked. On a specified date at a specified time, an unlocked medication cart was observed to be in the hallway in front of a dining room. An RPN indicated that they forgot to lock the medication cart when they administered medications to residents in the dining room. All residents were in the dining room at the time of the observation.

Sources: Observation on a specified date.