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

Public Report

Report Issue Date: March 18, 2025
Inspection Number: 2025-1364-0002
Inspection Type: Proactive Compliance Inspection
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): February 25, 26, 27, 2025 and March 3, 4, 5, 6, 7, 10, 11, 12, 13, and 14, 2025

The following intake was inspected:

- Intake: #00140734 - PCI

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the required information, specifically the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, was posted in the home.

- During the initial tour of the home it was noted that the policy to promote zero tolerance of abuse and neglect of residents was not posted. When asked, staff were unable to locate the posted policy.
-On a later date the inspector noted the policy to promote zero tolerance of abuse and neglect of residents had been posted in the home's main lobby.

- Staff presented the inspector with a copy of the home's policy of zero tolerance of

abuse and neglect of resident and stated it would be posted.

Source: inspector's observations, Interview with staff.

Date Remedy Implemented: February 27, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 food was being served at a temperature that was safe and palatable.

On a specific date, a warm food item was put on the table for a resident, which was prepared several minutes before. The item had been left on the table unattended for over five minutes before a staff turned toward the resident and took the item to start feeding the resident. The inspector asked the staff about the temperature of the warm food item and another staff immediately came to the table and indicated that they needed to take the temperature and that it should be at least 140 degrees Celsius. The temperature was 127.2 degrees Celsius.

Later, the staff took away the warm food item and prepared another one that was given to the resident. After this another staff fed the resident the warm food item that was safe and palatable.

Sources: breakfast observation, and interviews with staff

Date Remedy Implemented: February 27, 2025

WRITTEN NOTIFICATION: Administration

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (2)
Resident and Family/Caregiver Experience Survey
s. 43 (2) Where the regulations provide for how the survey is to be administered, the licensee shall ensure that the survey is administered in the manner and in the form provided for in the regulations, and that it contains the content provided for in the regulations.

The Resident and Family/Caregiver Experience Survey that was administered did not contain the content provided for in the regulations. Specifically, it did not contain contents to measure the residents', families', caregiver's experience with the care, services, programs and goods provided at the home.

Source: Resident and Family/Caregiver Experience Survey for 2025 and interview with staff.

WRITTEN NOTIFICATION: Advice

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey

s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The advice of the Family Council, was not sought in acting on the results of the Resident and Family/Caregiver Experience Survey.

Sources: Family Council meeting minutes and interview with the family council chair.

WRITTEN NOTIFICATION: Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (5) (b)
Resident and Family/Caregiver Experience Survey
s. 43 (5) The licensee shall ensure that,
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;

1) The actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey were not documented and made available to the Family Council.

Sources: Family council meeting minutes and interview with the family council chair.

2) The actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the Resident and Family/Caregiver Experience Survey had not been made available to the Residents' Council of the Long-Term Care Home as confirmed by staff.

Sources: Resident council meeting minutes and interview with staff.

WRITTEN NOTIFICATION: Doors in a home

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that a door leading to a non-residential area was kept locked to restrict access by residents to the area when not being supervised by staff. Specifically, the licensee has failed to ensure that the door to a janitor's room, on a specific unit which contained cleaning supplies, was locked. Two staff indicated the lock was not working but that they had not been aware of this.

Source: inspector's observation and interview with staff.

WRITTEN NOTIFICATION: Air temperature

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (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.

The licensee has failed to ensure that the air temperature, that was required to be measured and documented, was measured and documented for time periods on twenty one specific dates from May 15 to September 17, 2024.

Sources: home's Air Temperature logs dated May 15, 2024 to September 17, 2024 and interview with staff.

WRITTEN NOTIFICATION: Air temperature

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (5)
Air temperature
s. 24 (5) The licensee shall keep a record of the measurements documented under subsections (2), (3) and (4) for at least one year.

The licensee has failed to ensure there were records kept of the documented air temperature measurements for the period of September 18, 2024 to March 10, 2025.

Sources: home's Air Temperature log and interview with staff.

WRITTEN NOTIFICATION: General requirements

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under

paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the written record of the annual skin and wound care program evaluation included the dates that the changes made to the program were implemented.

Source: home's Annual Program Evaluation Tool.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that a written record was kept relating to the evaluation of the home's staffing plan for the year 2023 as confirmed by staff.

Source: Interview with staff.

WRITTEN NOTIFICATION: Medication management system

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the "Documentation of Narcotic and Controlled Medication Counts Policy (7.5)" reviewed July 31, 2024. was implemented.

The policy requires under Option A: Combined Narcotic/Controlled Medication Count record;

"5. When administering the Narcotic/Controlled medication, nurse documents for the administration of the medication on the resident's MAR and on the Combined Narcotic/Controlled Medication Count Record."

On March 4, 2025, after administering a narcotic and a controlled substance, a registered staff did not document on the "Combined Narcotic/Controlled Medication Count Record, the administration of the narcotic/controlled substance

as per policy.

Sources: Observation and interviews with registered staff.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 3.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to comply with the Drug destruction and disposal policy that requires registered nursing staff to be two staff to transport the Narcotic/Controlled Substances to the specific area for destruction and for the disposal of wasted medications, the registered staff should be denaturing and placing the wasted medication in the medical disposal container.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that the Drug destruction and disposal policy is complied with.

Specifically, two registered staff indicated the narcotic was not always transported by two registered nurses to the specific medication room for destruction and they did not denature the wasted medication but used the yellow sharp container .

Sources: interviews with registered staff and home's policy, Destruction and Disposal of Narcotic and Controlled Medications (7.7)

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (1)
Continuous quality improvement committee
s. 166 (1) Every licensee of a long-term care home shall establish a continuous quality improvement committee.

The licensee has failed to to ensure that a continuous quality improvement committee was established for the home as confirmed by staff.

Source: interview with staff.

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A. Educate four specific staff on the correct way to wear a mask based on evidence based best practices. Training for these staff must be completed by an appropriately qualified Infection Prevention and Control (IPAC) staff.
B. Educate a specific staff on when masks are required to be worn and under what circumstances staff can stop wearing their masks.
C. Written records must be maintained of the requirements under steps A and B and must include a copy of the training provided, those who attended with dates and times, as well as the name of the person who provided the training. Written records must be kept as required until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

1) The licensee has failed to ensure compliance with any standard issued by the Director with respect to infection prevention and control (IPAC). Specifically, the licensee has failed to ensure compliance with section 6.7 of the IPAC Standard for Long-Term Care Homes in that all staff and support workers comply with applicable masking requirements at all times when during outbreaks on Heritage and Cottage units, where staff were required to wear their masks at all times. It was observed that two staff on a specific unit were not wearing their masks correctly, one staff on another unit was not wearing their mask correctly and another staff on the same unit

was not wearing a mask.

Sources: inspector's observation and interviews with staff.

2) The licensee has failed to ensure the implementation of standard or protocol issued by the Director with respect to infection prevention and control.

The Director issued the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes" in April 2022, revised September 2023.
Additional Requirement 9.1 of the IPAC Standard requires the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:
b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact);

Specifically, during a medication pass observation, a registered staff was observed not doing hand hygiene in between residents to whom they administered medications. The registered staff indicated that they are to do hand hygiene in between residents when administering medications.

Sources: Observation and interview with registered staff.

This order must be complied with by April 28, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

The follow orders were issued to O. Reg. 246/22 s.102 (20 (b)
NCR was issued on June 10, 2024
WNs were issued on July 27, 2022 and March 15, 2023,
COs were issued on December 9, 2022 and August 13, 2024

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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.