Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 26, 2018	2018_486653_0004	000141-17, 003682-17, 001484-18	Critical Incident System

Licensee/Titulaire de permis

Grove Park Home for Senior Citizens
234 Cook Street BARRIE ON L4M 4H5

Long-Term Care Home/Foyer de soins de longue durée

Grove Park Home For Senior Citizens
234 Cook Street BARRIE ON L4M 4H5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ROMELA VILLASPIR (653), DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 31, February 1, 2, 5, and 6, 2018.

During the course of the inspection, the inspector observed staff to resident interactions, reviewed staff schedule, clinical health records, the home's investigation notes, and relevant home policies and procedures.

The following Critical Incident (CI) intakes had been inspected concurrently:

Log #: 000141-17 related to staff to resident neglect.
Log #: 003682-17 related to staff to resident abuse.
Log #: 001484-18 related to a medication incident/ adverse drug reaction.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Maker (SDM), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Nurse Practitioner (NP), and the interim Director of Care (iDOC).

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provided direct care to the resident.

On an identified date and time, the home submitted a Critical Incident Report (CIR) to the Ministry of Health and Long-Term Care (MOHLTC), related to an allegation of staff to resident neglect. The CIR indicated that resident #001 did not receive care on an identified date.

Interview with resident #001's Substitute Decision-Maker (SDM) identified that they arrived to see resident on an identified date at an identified time to find resident in need of personal care and assistance.

Record review identified that resident #001 had responsive behaviours and that they required two staff for care. The plan of care identified strategies that the staff can utilize when providing care to resident #001.

An interview with Personal Support Worker (PSW) #117 identified that resident #001's normal routine was to not get the resident up until after an identified time, and that providing care was often challenging because of the resident's responsive behaviours during care.

Interview with PSW #118 revealed that resident #001 had responsive behaviours and could be resistive to care. Interview with PSW #120 further revealed the resident would exhibit identified responsive behaviours during care but that they always had good

results because they were calm. PSW #120 stated that they were often assigned to resident #001's care as they were more successful and that it seemed unfair as the resident's care was hard to do. Interview with PSW #122 identified that they had not provided care to resident #001 since September 2016, upon the family's request.

Record review identified that PSWs #117, #118, #120, and #122 worked the shift on an identified date. All staff confirmed that resident #001 was placed into PSW #122's assignment and that it was known that PSW #122 could not provide resident #001's care.

Interview with PSW #120 confirmed that care provided to resident #001 was late, and the family was aware and upset. PSW #120 revealed that there was lack of clear direction on who was to provide care to resident #001 and that staff did not volunteer as providing care was often challenging.

Record review and interview with Registered Practical Nurse (RPN) #123 confirmed that when they stepped into the RPN role on an identified date, and entered resident #001's room at an identified time, care had just been provided by PSW #120. RPN #123 confirmed that care was late and that there was a lack of clear direction on who was to provide resident #001's care that shift.

Record review of an e-mail from RPN #123 written on an identified date, to the Director of Care (DOC), identified that the PSW/ resident assignment sheets in place that shift placed resident #001 in PSW #122's assignment.

Interview with the interim DOC (iDOC) confirmed that there was a lack of clear direction provided on which two staff were providing care to resident #001, and the lack of direction resulted in a delay of care being provided to resident #001. [s. 6. (1) (c)]

2. The licensee has failed to ensure that care had been provided to the resident as specified in the plan.

On an identified date and time, the home submitted a CIR to the MOHLTC, related to a medication incident that altered a resident's health status. The CIR indicated that on an identified date and time, the resident received a medication that had been reconstituted in a medication the resident was allergic to. The resident had already been experiencing identified symptoms requiring further assessment by the Nurse Practitioner (NP) who ordered a medication to be reconstituted in an identified medication. The resident

deteriorated further in the evening and was transferred to the hospital.

Review of the resident's admission profile and admission information form, revealed their list of identified allergies including the identified medication. Review of resident #002's progress notes on an identified date, revealed the resident had been been experiencing identified symptoms for a medical condition, between an identified period of time. Within the same day, the NP ordered a medication to be reconstituted in an identified medication, to be given to the resident, every 24 hrs for 5 days, and other identified nursing interventions. RPN #100 administered the medication on the same day at an identified time. Later on in the evening, resident #002's condition declined and they were sent to the hospital for further assessment.

Review of the hospital's consultation document revealed that the resident had been transferred to the hospital and the reason for the referral was an identified medical diagnosis.

Review of progress note on an identified date, indicated that the RN received a call from pharmacy regarding the orders written by the NP on the identified date, for a medication that was mixed with an identified medication. Pharmacy informed the RN that the resident had a listed allergy for the identified medication. The RN called the hospital and informed the nurse of the medication incident. The RN called the SDM and notified them of the incident.

Interviews with RPN #100, RN #105, and the NP, stated they had been aware that resident #002 was allergic to various things, however, they did not realize that the resident was allergic to the identified medication. The RPN confirmed that on the identified date at an identified time, they administered the medication reconstituted in the identified medication, to resident #002. The RPN and the RN confirmed that in this case, care had not been provided to resident #002 as specified in their plan, as the resident received a medication they were allergic to. The RPN, RN, and the NP, confirmed that the medication error resulted in a change of health condition to resident #002 resulting in further hospital assessment.

Interview with the iDOC acknowledged the above mentioned medication incident and confirmed that the resident had been administered a medication they were allergic to as identified in their written plan of care. The iDOC further indicated that care was not provided to resident #002 as specified in their plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident, and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

According to O. Reg. 79/10, s. 114 (2), The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Review of Medical Pharmacies' policy titled "Ordering Medications" policy #4-2, dated February 2017, indicated the following under procedure for completing the prescriber's order sheets and processing prescriber's orders:

"Press firmly using a digital pen on digital paper or a ballpoint pen on plain paper to ensure legibility. Ensure each order has all areas completed. Nurse ensures order is accurately transcribed to the MAR". Medical pharmacies' user's manual also indicated that the nurse must check all orders entered on the PCC chart against the prescriber's order to perform 1st and 2nd checks".

Review of resident #002's digital prescriber's orders form on an identified date, indicated the NP's new orders. Review of the physician's orders on PCC revealed that RPN #100 transcribed the orders on the same day. Further review of the digital prescriber's orders form revealed that the first check was done by the registered staff working the next shift, on the following day, and a second check had not been completed.

Interview with RPN #100 confirmed that they had administered the medication to resident #002 the day it was ordered, prior to transcribing and processing the NP's new orders. The RPN further indicated their awareness of the home's policy that required the registered staff to process the new orders by transcribing them to PCC if it was after pharmacy hours, prior to administration. The RPN also confirmed they did not comply with the home's policy related to transcribing new orders.

Interview with the iDOC acknowledged the above mentioned information, and indicated that the home's expectation was for two registered staff to do the first and second checks, process and transcribe the order as per the policy, prior to administration, with the exemption of a STAT order that needs to be given immediately. The iDOC further acknowledged that the medication was not written as a STAT order, and confirmed that the policy on ordering medications had not been complied with in this medication incident. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policy on "Ordering Medications" is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to report to the Director the results of every investigation undertaken under clause (1) (a).

On an identified date and time, the home submitted a CIR to the MOHLTC, related to an allegation of staff to resident abuse. The CIR indicated that on an identified date and time, the LEC approached the DOC with a resident concern that was brought forth during the resident leadership meeting. Resident #003 and their family member met with the LEC and reported that a staff was curt when talking to them, and claimed the PSW made an inappropriate statement to the resident. The resident further indicated that the staff pulled out the call bell from the wall and let it drop to the floor so the resident could not ring at an identified shift. Further review of the CIR did not indicate that it had been amended with the results of the investigation.

Review of the home's investigation notes and interview with the iDOC indicated that an investigation had been conducted related to the CIR. The iDOC stated that abuse could not be verified based on their investigation, and that they were not aware that the CIR had to be amended to inform the Director of the results of the investigation. The iDOC confirmed that the Director had not been informed of the results of the home's investigation as required. [s. 23. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 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.

On an identified date and time, the home submitted a CIR to the MOHLTC, related to an allegation of staff to resident abuse. The CIR indicated that on an identified date and time, the LEC approached the DOC with a resident concern that was brought forth during the resident leadership meeting. Resident #003 and their family member met with the LEC and reported that a staff was curt when talking to them, and claimed the PSW made an inappropriate statement to the resident. The resident further indicated that the staff pulled out the call bell from the wall and let it drop to the floor so the resident could not ring at an identified shift.

Review of the LEC's statement indicated that on an identified date and time, they met with resident #003 and their SDM. The resident had the concerns with the staff providing care. Resident #003 alleged that the staff regularly pulled the resident's call bell out of the wall or puts it on the floor so that it was not accessible. The resident further indicated the staff made an inappropriate statement to them. Review of the CIR revealed that the LEC approached the DOC on the same day and the CIR was first submitted to the MOHLTC the following day.

Inspector #653 attempted to interview the LEC, however, they were not available for an interview.

Interview with the iDOC confirmed that the home considered the LEC's statement as an allegation of abuse, and that it should have been reported to the Director immediately. The iDOC acknowledged that the home did not report the allegation of abuse to the Director immediately as required. [s. 24. (1)]

Issued on this 27th day of February, 2018

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.