Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 6, 2019	2019_655679_0019	009894-19, 012997-19	Complaint

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

MICHELLE BERARDI (679), JENNIFER NICHOLLS (691)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 22 to 26, 2019.

The following intakes were inspected upon during this Complaint (CO) inspection:

- Two complaints submitted to the Director regarding resident care concerns.

A Critical Incident System Inspection (#2019_655679_0018) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Practitioner (NP), Wound Care Nurse, Rehabilitation Nurse, Physiotherapist, Registered Dietitian, Behavioural Supports Ontario Community Support Worker, Life Enrichment Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Nutrition and Hydration
Pain
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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	Légende 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 residents #001, #007, their substitute decision maker, and any other person designated by the resident or the substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the Director on a specified date, outlining concerns regarding resident #007's care.

In a telephone interview with the complainant they identified concerns regarding lack of communication, stating that a specified part of resident #007's plan of care was changed without the Substitute Decision Maker (SDM) being notified, and that they had requested a copy of a specified assessment, but never received it. The complainant further identified that they had requested follow-up from the home's staff after the Nurse Practitioner assessed resident #007's altered skin integrity and had never received the follow-up.

A) Inspector #679 reviewed resident #007's electronic progress notes and identified that on a specified date, Rehabilitation Nurse #111 implemented changes to the plan of care for resident #007. The Inspector did not observe any documentation in the progress notes to identify that resident #007's SDM was involved in the change to resident #007's care plan.

A further review of the electronic record identified a progress note written by RPN #102, which identified that resident #007's SDM notified them that they were unaware of the changes to the residents care plan, and that they wished that they would have been made aware and involved in the changes.

Inspector #679 reviewed the policy titled “Resident Care Plans and ADL cards (policy # NUR-03-04)", last revised June 2017, which identified that “Each resident and/or their representative shall be supported to participate in the development and evaluation of the plan of care”.

In an interview with Inspector #679, RPN #102 indicated that resident #007’s SDM had come into assist resident #007 when they were notified of the change to the residents care plan. RPN #102 identified that the SDM was upset as they were not notified of the change. RPN #102 further identified that resident #007’s SDM should have been notified of the change to the care plan.

In an interview with Rehabilitation Nurse #111, they identified that there was a change in resident #007’s care plan as a result of a change in the residents health status. Rehabilitation Nurse #111 identified that they should have called the SDM to notify them of the change in the resident's care plan.

In an interview with Inspector #679, the DOC identified that when the home was making significant changes to the plan of care they would try and meet with the family ahead of time. The DOC further identified that if it was a family who requested to be involved, then the home would not make a change to the care plan without notifying the family.

B) Inspector #679 reviewed an electronic progress note which identified that Physiotherapist #124 contacted resident #007's SDM to discuss findings from a specified assessment. The progress note indicated that the Physiotherapist would provide a written report to the DOC for resident #007's SDM.

In an interview with the ADOC, they identified that they were unsure if resident #007's SDM had received the specified assessment report.

In an interview with Inspector #679, Physiotherapist #124 identified that they had assessed resident #007 for a specified reason. Physiotherapist #124 identified that they had contacted resident #007's SDM to discuss the findings of the assessment and that resident #007's SDM requested a copy of the specified assessment. Physiotherapist #124 indicated that the copy of a specified assessment had been provided to the DOC.

In an interview with the DOC they identified that they believed Physiotherapist #124 had provided the copy of the specified assessment to resident #007's SDM.

C) Inspector #679 reviewed correspondence between resident #007's SDM and the home. The correspondence from resident #007's SDM requested a follow up from the home's staff after a specified assessment was completed.

Inspector #679 reviewed the electronic progress notes and the physician progress notes and was unable to identify any documentation to indicate that staff had followed up with resident #007's SDM after the completion of the specified assessment.

In an interview with Nurse Practitioner (NP) #122 they identified that they did not speak with resident #007's SDM regarding their assessment. [s. 6. (5)]

2. A complaint was submitted to the Director related to care concerns of resident #001. The complaint identified that staff had administered medications to resident #001 without their consent.

Inspector #691 conducted a review of resident #001's paper chart where it was identified that, on a specified date, NP #122 prescribed an order for a specified medication. Inspector #691 noted that this order was processed by the registered staff and was also noted on the electronic medical record (EMAR). A further review of the EMAR noted that RPN #120 dispensed the medication as prescribed on a specified date.

Inspector #691 reviewed the progress notes over a specified period and could not identify that the home obtained consent from the SDM prior to administering this medication.

In an interview with RPN's #107, and #116, as well as RN's #103, #104, #105 and #120, they confirmed with Inspector #691, that the procedure for processing a medication order would be to notify the SDM to obtain consent prior to administering the medication to the resident.

In interviews with RN's #103 and #120, they further indicated to Inspector #691 that the SDM was not notified of the new medication order, and therefore staff did not obtain consent prior to administering the medication to resident #001.

In interview with Inspector #691, the DOC confirmed that the SDM was not notified of the new medication order for resident #001. The DOC further confirmed that it was their expectation that as per their current process, the SDM should be notified for any

medication change prior to administering medication. [s. 6. (5)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as outlined in the plan.

A complaint was submitted to the Director outlining concerns regarding resident #007's care.

Inspector #679 reviewed correspondence from the complainant, which was received by the Inspector. The correspondence identified that there were concerns regarding resident #007's nutrition intake, and that they were unsure if a specified nutrition related intervention was being completed.

Inspector #679 reviewed the resident's electronic Point Of Care (POC) documentation record for the a specified period. The POC task identified a specific nutrition related task/intervention and instructed staff to document/chart if the task/intervention was refused to indicate that alternate attempts had been tried. The Inspector did not identify that staff had documented the implementation of the task/intervention as outlined in the POC task.

In an interview with RPN #106, they identified that there was a specified nutrition intervention in place for resident #007.

Together, Inspector #679 and RN #117 reviewed the electronic documentation record. RN #117 identified that the resident would have been available for the task/intervention to be completed. RN #117 identified that they would have to follow up with staff to identify this was being charted a specified way.

Together, Inspector #679 and the DOC reviewed the documentation report and identified the occasions in which staff documented a refusal with no follow up documentation. The DOC identified that the expectation would be that staff follow the task on POC. [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 ensuring that resident #001, #007, and all other residents of the home, and their Substitute Decision Makers (SDM) are given the opportunity to participate fully in the development and implementation of the residents plan of care; and that the plan of care is provided to resident #007 as specified in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee immediately forwarded any written complaints that had been received concerning the care of a resident or the operation of the home to the Director.

A complaint was submitted to the Director related to care concerns of resident #001. The complainant stated that the management of the home was not dealing with their specified concerns.

During a telephone interview, Inspector #691 spoke to the complainant who indicated that there had been a written complaint sent to the home's DOC and Executive Director (ED). The complainant indicated to the Inspector that they felt that the home was not addressing their concerns regarding resident #001, and further indicated that they had other complaints regarding resident #001 receiving medications without their consent, and the resident having altered skin integrity related to being in an inappropriate mobility aid for long periods of time.

Inspector #691 requested the complaints log from the home for 2019 from the home's ED. Inspector #691 reviewed the written complaint regarding resident #001 as well as the actions of the management of the home, and observed no further follow up with the complainant after a specified date.

The Inspector reviewed the complaint from resident #001's family member received by the DOC and ED. The written complaint indicated specified concerns. The home's ED responded to the complaint on a specified date. A further review of the documents related to the complaint indicated that this written complaint was not submitted to the Director as required.

On December 18, 2018, the Director notified the Long-term Care Homes, via the Ministry of Health and Long-Term Care Portal of "Important reference materials on the mandatory reporting requirement", specially a question and answer document titled "Reporting QA MOH". The Reporting QA MOH indicated that a specified type of written complaints to the home were considered written complaints and were to be reported as per legislative requirements.

Inspector #679 reviewed the home's policy titled "Complaint Management Policy and Procedure" which identified that if the complaint was written, a copy of the written complaint concerning the care of a resident or the operation of the long-term care home shall immediately be forwarded to the Centralized Intake, Assessment and Triage Team at MOHLTC.

In an interview with Inspector #691, the DOC indicated that their understanding of the home's policy was that written complaints were only forwarded to the Director if they were not able to be resolved. The DOC also indicated that they did not consider an email to be a written complaint, as this was a form of communication with the home and the family members. The DOC confirmed that the written complaint had not been forwarded to the Director, as they did not feel this was a written complaint and follow up was done.

In an interview with the ED, they indicated that they received a concern regarding resident #001 on a specified date. They indicated that they had addressed the concerns of the complainant. They indicated that they felt this concern was not a written complaint, it was a form of communication tool for this family. They indicated that they were aware of the requirement to forward written complaints that the licensee received to the Director, immediately. The ED further indicated to the Inspector, that they made an error, they should have followed the complaints process as per the homes policy, and submitted to

the Director as this was a written complaint. [s. 22. (1)]

2. A complaint was submitted to the Director related to care concerns of resident #007. The complaint identified that the management of the home did not respond to their requests for meetings to discuss their care concerns regarding resident #007.

During a telephone interview, Inspector #679 spoke with the complainant, who indicated that they had requested several meetings to discuss their concerns with the management of the home. The complainant identified that they were concerned with the lack of communication in the home.

Inspector #679 reviewed written correspondences which were sent to the home regarding the care of resident #007.

Inspector #679 reviewed the home's complaint log for 2019 which was provided by the ED. The Inspector did not identify any documentation or follow up to the correspondences which were forwarded to the home on specified dates.

In an interview with the ADOC, they identified that they had received the concern and had followed up with the complainant. The ADOC identified they didn't view the correspondence as a complaint.

In an interview with the DOC, they identified that if the home received a written complaint or email, which was outside their normal communication, then the complaint was forwarded to the homes ED, who was in charge of complaints.

Together, Inspector #679 and the ED reviewed the correspondence between the complainant and the home. The ED identified that these correspondence were complaints and that the home had failed to document and notify the Director of the complaints. [s. 22. (1)]

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 ensuring that the licensee immediately forwards any written complaints which are received concerning the care of residents or the operation of the home to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments, and was reassessed at least weekly by a member of the registered nursing staff.

A complaint was submitted to the Director related to care concerns of resident #007.

During a telephone interview with Inspector #679, the complainant stated that they were concerned with resident #007's areas of altered skin integrity.

Inspector #679 reviewed the electronic progress notes and identified a progress note written on a specified date, which identified that resident #007's family member reported an area of altered skin integrity. A further review of resident #007's progress notes identified that resident #007's area of altered skin integrity was assessed by the Nurse Practitioner on a specified date.

The Inspector was unable to identify any further assessments of the resident's altered skin integrity, until it was healed a number of weeks later.

In an interview with RN #117, they identified that wound assessments were to be completed weekly. Together, Inspector#679 and RN #117 reviewed the electronic progress notes. RN #117 identified that NP #122 completed a wound assessment on a specified date. RN #117 further identified that they did not see any charted entries on the assessment, and that this should have been charted in the residents progress notes.

In an interview with Inspector #679, Wound Care Nurse #112 identified that wound assessments were to be completed weekly under a skin and wound note in PCC. Wound Care Nurse #112 identified that there should have been documentation to indicate how the treatment was progressing.

In an interview with Nurse Practitioner #122, they identified that they had assessed resident #007 and noted an area of altered skin integrity. NP #122 identified that there should have been assessments in the documentation. [s. 50. (2) (b) (iv)]

2. A complaint was submitted to the Director related to care concerns of resident #001.

During a telephone interview with Inspector #691, the complainant stated that resident #001 had an area of altered skin integrity related to being in an inappropriate mobility aid. The complainant stated to the Inspector that they have been waiting too long for the new mobility aid for resident #001.

In a review of resident #001's electronic record, it was identified that they were assessed by NP #122 on a specified date, as having an area of altered skin integrity.

In a further review of the electronic record, paper chart and wound book, the Inspector

was only able to identify skin and wound notes documented in the resident's electronic record on six occasions for a 10 week period.

Inspector #691 reviewed the skin and wound note documentation written by RPN #120 on a specified date, which indicated that the area of altered skin integrity had healed.

A review of the policy titled "Skin and Wound Care" last revised November 2018, identified that for residents with a specified type of altered skin integrity, registered staff were to reassess the altered skin integrity weekly.

In an interview with RPN #120, they reported that staff were required to have documented skin and wound notes with every specified treatment, and weekly at a minimum. Together, Inspector#691 and RPN #120 reviewed the skin and wound notes for resident #001, they identified that there were only six skin and wound notes related to the area of altered skin integrity over a 10 week period. RPN #120, confirmed to the Inspector that the documentation should have been completed and must have been missed.

In an interview with RN #116, they indicated that a specified area of altered skin integrity would have, at a minimum, weekly wound notes, and these would be documented in the electronic record. Together with Inspector #691, RN #116, reviewed resident #001 skin and wound notes, it was identified that there were only six notes documented related to the residents altered skin integrity over a 10 week period.

During an interview with the DOC #101, they reported to Inspector #691 that staff were required to have documentation under skin and wound notes with every specified treatment, and a weekly wound assessment done for a specified type of altered skin integrity. Together with the Inspector, they reviewed the missing documentation under skin and wound notes for resident #001, for the time period a specified period. The DOC identified that there were not weekly assessments documented in resident #001's electronic medical record. The DOC confirmed that the expectation of the Registered Staff was to have skin and wound notes documented after each wound treatment, and Nursing assessment, and that this was not done for resident #001. [s. 50. (2) (b) (iv)]

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 ensuring that any resident exhibiting altered skin integrity is assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments, and that the wound is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007 was offered a between-meal beverage in the morning and afternoon and a beverage in the evening.

A complaint was submitted to the Director outlining concerns regarding resident #007's care.

Inspector #679 reviewed email correspondence which was received by the Inspector on a specified date. The correspondence identified that there were concerns regarding resident #007's nutritional intake, and that they were unsure if a specified task/intervention was being completed.

Inspector #679 reviewed resident #007's electronic POC tasks and identified a specified intervention.

On a specified date, Inspector #679 observed the tea cart pass on a specified home area. The Inspector observed a PSW walk by resident #007's room. The Inspector later observed the staff member return the nutrition cart to the kitchen.

Inspector #679 reviewed resident #007's documentation record and identified that resident #007 was documented as "Resident Not Available".

In an interview with PSW #100, they identified that the tea cart was passed at specified times, and that any resident who was awake received fluids. PSW #100 confirmed at the time of the interview that the tea cart was finished. Inspector #679 questioned if resident #007 had received their fluids, and PSW #100 identified that resident #007 did not receive their fluids as they were asleep.

In an interview with RPN #106, they identified that there was a specific nutrition task/intervention in place for resident #007.

Together, Inspector#679 and RN #117 reviewed the electronic documentation record. RN #117 identified that the resident would have been available for the fluids. RN #117 identified that they would have to follow up with staff to identify this was being charted under "Resident Not Available".

Together, Inspector#679 and the DOC reviewed the documentation report and identified the occasions in which staff documented that the resident was not available or refused. The DOC identified that the expectation would be that staff follow the task/intervention on POC. [s. 71. (3) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee, that a response had been made to the person who made the complaint indicating what the licensee had done to resolve the complaint.

A complaint was submitted to the Director outlining concerns regarding resident #007's care.

In a telephone interview with the complainant they identified that resident #007's care plan had been changed without them being involved, and that they had requested a meeting from the home to discuss the resident's care on a number of occasions, but that the meeting had not occurred.

Inspector #679 reviewed correspondence dated a specific date between resident #007's SDM and the home's ED. The email from resident #007's SDM identified that they were not notified of the changes to resident #007's plan of care prior to the changes being implemented. The email from resident #007's SDM further identified that they had requested a meeting with the home to discuss resident #007's care. The correspondence from the homes ED identified that the home would follow up with a time to meet to review the SDMs concerns.

In an interview with the ED, they identified that the home had failed to respond to the complainant regarding the request for the meeting. [s. 101. (1) 3.]

Issued on this 8th day of August, 2019

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

Original report signed by the inspector.