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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: July 28, 2023

Inspection Number: 2023-1433-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: Grove Park Home for Senior Citizens

Long Term Care Home and City: Grove Park Home For Senior Citizens, Barrie

Lead Inspector	**Inspector Digital Signature**
Kim Byberg (729)	Kimberly Byberg Digitally signed by Kimberly Byberg Date: 2023.07.31 14:55:45 -04'00'

Additional Inspector(s)
Blake Webster (000689)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 26 - 28, 2023, and July 4 - 5, 2023.
The inspection occurred offsite on the following date(s): June 29 - 30, 2023.

The following intake(s) were inspected during this Critical Incident (CI) inspection:
· Intake: #00084416, and Intake: #00086425, related to fall prevention and management

The following intake(s) were inspected during this Complaint inspection:
· Intake: #00088362 and #0008642 related to an allegation of abuse
· Intake: #00090337 related to pain management

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

The licensee failed to ensure that all doors leading to stairways were kept locked.

Rationale and Summary
On two resident home areas there were two stairways located in the hallway beside resident rooms. The doors to the stairways were equipped with half-length swinging doors with a hook latch at the back of door to keep the doors closed.

There was not a lock on the half-length swinging door and could easily be unlatched by reaching over the door.

The residents were at risk of injury when the doors leading to stairways were not kept locked.

Sources:
Photos of the doors on two units, Video footage of the unlocked door, interview with the Administrator and Environmental Inspector, Long-Term Care Home Design Manual 2015, Ministry of Health and Long-Term Care February 2015, section 8.2 page 36.
[729]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. iii.

The licensee failed to ensure all doors leading to stairways were equipped with an alarm is cancelled at the point of activation, was connected to the resident - staff communication system or had an audio-visual enunciation that was connected to the nursing station nearest to the door and had a manual reset switch.

Rationale and Summary
The stairways on two resident home areas that had half-length swinging doors in place were not equipped with alarm or device that alerted staff to unauthorized access to the stairway.

The residents were at risk of injury when the doors leading to stairways were not equipped with an alarming system to alert staff when there was access to the stairway.

Sources:
Photos of the doors on two units, Video footage of the unlocked door, interview with the Administrator and Environmental Inspector, Long-Term Care Home Design Manual 2015, Ministry of Health and Long-Term Care February 2015, section 8.2 page 36.

[729]

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. ii.

The licensee failed to ensure that doors leading to a stairway were equipped with a door access control system that was kept on at all times.

Rationale and Summary
The stairways on two resident home areas that had half-length swinging doors in place were not equipped with a door access control system that was kept on at all times that prevented residents from unauthorized access to the stairway.

The residents were at risk of injury when the doors leading to stairways were not equipped with a door access control system to prevent residents from access to the stairway.

Sources:
Photos of the doors on two units, Video footage of the unlocked door, interview with the Administrator and Environmental Inspector, Long-Term Care Home Design Manual 2015 Ministry of Health and Long-Term Care February 2015, section 8.2 page 36.
[729]

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) (i)

The licensee failed to ensure that when a resident exhibited altered skin integrity, they received 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 assessment.

Rational and Summary
A resident had altered skin integrity. On a specific day, an assessment of the area was required. A skin and wound assessment was not completed using a clinically appropriate assessment tool.

The Director of Care confirmed that there wasn't an appropriate clinical tool used to assess the residents wound when the altered skin integrity was identified.

The lack of assessment may have resulted in the resident being exposed to unnecessary risk due to the home not having an appropriate clinical skin and wound assessment tool.

Sources
Critical Incident Report, resident's skin and wound assessments, progress notes, MAR, Treatment administration record (TAR), head to toe assessment, skin and wound care policy, Bates-Jensen Wound Assessment Tool, Interview with DOC #103 and other sources.

[000689]

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that when a resident was experiencing an exacerbation of an acute medical condition they were assessed using a clinically appropriate pain assessment instrument.

Rationale and Summary
A resident had been experiencing new episodic pain that was being investigated and treated by the

home's physician and nurse practitioner (NP).

For two days the resident experienced an increase in pain. The resident had utilized all of their prescribed pro re nata (PRN) medications. Follow up pain documentation on three occasions stated that the effectiveness of the analgesic administration was unknown and on one occasion it was ineffective.

Two days later, the resident requested to be seen by the physician or NP as they continued to have pain. For all the days the resident experienced pain there was no Abby or OPQRST pain assessments completed to assess their pain, and no additional communication to the physician or NP until their next scheduled visit that occurred four days after the resident's request to see the physician.

The DOC stated when the resident was experiencing a change in condition and had acute pain, the Abby or OPQRST assessment should have been completed.

The resident was negatively impacted when the registered staff did not complete pain assessments using the home's clinically appropriate pain assessment tools. As a result of assessments not being completed it may have delayed prompt assessment and additional treatment by the physician or NP to assist in managing the residents' pain.

Sources:
Resident's eMAR PAINAD scores, progress notes, Policy Titled: Pain Management Program, revised May 2023, Abby and OPQRST pain assessment and care plan. Interview with the resident, RPN, NP, and DOC.

[729]