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
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Original Public Report

Report Issue Date: November 28, 2023
Inspection Number: 2023-1433-0003
Inspection Type: Critical Incident
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
Gabriella Del Principe (741734)	Gabriella Del Principe Digitally signed by Gabriella Del Principe Date: 2023.12.06 13:28:47 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 30-31, 2023, November 2, 6-10, 2023.

The following intakes were completed in this Critical Incident (CI) inspection:
- Intake #00094331 was related to the use of glucagon and transfer to hospital.
- Intake #00096930 was related to a fall resulting in injury.
- Intake #00097251 was related to a fall resulting in injury.

The following intake was completing during this inspection: Intake #00091405 was related to falls prevention and management.

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Medication Management

Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Collaboration of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee failed to ensure that staff members involved in a resident's care collaborated with each other to ensure that assessments are integrated and complement each other.

Rationale and Summary

A Registered Practical Nurse (RPN) completed a skin and wound assessment on a resident's existing wound, and noted a sign that was indicative of an infection.

The Nurse Practitioner or Physician were not informed of the change in the resident's wound when there was no evidence of healing.

Failure to inform the Nurse Practitioner or Physician that the resident's wound had worsened prevented further assessment and monitoring of the wound, placing the resident at risk.

Sources: Resident's clinical health records, interview with RPN, and the Director of Care (DOC). [741734]

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. i.

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

Rationale and Summary

On Aspen and Maple 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. The hook latch at the back of the door could be accessed and unlocked by reaching over the half-length swinging door.

The Executive Director acknowledged that concerns related to the half-length swinging doors were identified in the previous inspection and demonstrated that a contractor has been acquired to install two fire rated steel doors, with an expected start date of Wednesday, November 15, 2023.

On Friday, November 10, 2023, the home installed a temporary physical barrier to ensure that residents could not access the two stairways on the Aspen and Maple resident home areas, until the start of the renovations.

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

Sources: Inspector #741734's observations of doors on Aspen and Maple home area, photos of the doors on Aspen and Maple home area, Purchase Order Agreement

between Grove Park Home for Senior Citizens and the contractor, and interviews with the Executive Director. [741734]

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 Aspen and Maple resident home area 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 Executive Director acknowledged that concerns related to the half-length swinging doors were identified in the previous inspection and demonstrated that a contractor has been acquired to install two fire rated steel doors, with an expected start date of Wednesday, November 15, 2023.

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: Inspector #741734's observations of doors on Aspen and Maple home area, photos of the doors on Aspen and Maple home area, Purchase Order Agreement between Grove Park Home for Senior Citizens and the contractor, and interviews

with the Executive Director. [741734]

WRITTEN NOTIFICATION: Doors in a Home

NC #004 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 that can be 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 Aspen and Maple resident home area that had half-length swinging doors in place were not equipped with an alarm or device that alerted staff to unauthorized access to the stairway.

The Executive Director acknowledged that concerns related to the half-length swinging doors were identified in the previous inspection and demonstrated that a contractor has been acquired to install two fire rated steel doors and alarms. The alarms will be cancelled at the point of activation and audio-visual enunciation will be connected to the nursing station with a manual reset switch. The expected start date was Wednesday, November 15, 2023.

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: Inspector #741734's observations of doors on Aspen and Maple home area,

photos of the doors on Aspen and Maple home area, Purchase Order Agreement between Grove Park Home for Senior Citizens and the contractor, and interviews with the Executive Director. [741734]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee failed to reassess a resident's wound on a weekly basis.

Rationale and Summary

An RPN completed a skin and wound care assessment on a resident's wound, using the Bates Jenson Wound Assessment tool. Upon completion of the assessment, the resident's wound dressing was changed as there was a sign indicative of an infection.

Upon review of the resident's clinical records, a weekly skin and wound assessment had not been completed since the wound had changed.

Failure to reassess the resident's wound weekly after it demonstrated a sign of an infection may have impacted prescribed treatment and care and placed the resident at risk.

Sources: Resident's clinical health records, Critical Incident report, Skin and Wound Care policy, interviews with RPN, and the DOC. [741734]

WRITTEN NOTIFICATION: Late Reporting to the Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee failed to inform the Director of a critical incident within the required time frame.

Rationale and Summary

A resident was transferred to hospital after they sustained a fall.

The DOC confirmed that the incident should have been reported to the Director once the resident returned from hospital and there was a significant change in the resident's health condition.

Failure to inform the Director may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Critical Incident report, resident's clinical health records, and interview with the DOC. [741734]

WRITTEN NOTIFICATION: Late Reporting to the Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 6.

The licensee failed to inform the Director of a critical incident within the required time frame.

Rationale and Summary

A resident experienced a medical event and was transferred to hospital. The Director was informed of this critical incident three days later.

The DOC confirmed that the incident should have been reported to the Director within one business day.

Failure to inform the Director within one business day may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Critical Incident report, resident's clinical health records, and interview with the DOC. [741734]