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: June 7, 2024	
Inspection Number: 2024-1433-0003	
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 Mark Molina (000684)	**Inspector Digital Signature**
Additional Inspector(s) Dianne Tone (000686)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 7-10, 14-17, 2024

The following intake(s) were inspected:

- Intake: #00108201 - CI: 2950-000008-24 - related to a COVID outbreak
- Intake: #00111785 - CI: 2950-000012-24 - related to a fall
- Intake: #00112575 - IL-0124599-AH/ CI: 2950-000013-24 - resident to resident altercation resulting in injury
- Intake: #00112818 - CI: 2950-000014-24 - unexpected death of a resident

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

Medication Management

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that fall interventions specified in the plan of care of a resident were in place.

Rationale and Summary
A resident’s fall prevention strategies were not observed to be in place.

It was acknowledged by staff that the resident’s fall prevention strategies should have been in place at the time of observation.

When the resident’s fall prevention strategies were not utilized, it put the resident at risk of injury.

Sources: Observations, Interviews with staff

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from physical abuse by another resident.

In accordance with Ontario Regulations (O. Reg.) 246/22 s. 2 (1) defines physical abuse under (c) as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
During an altercation between two residents, one of them sustained a physical injury.

The Director of Care (DOC) stated that a resident was injured as a result of an altercation with another resident.

Failure to protect a resident from physical abuse by another resident, resulted in a physical injury.

Sources: Resident clinical notes; Interview with staff

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WRITTEN NOTIFICATION: Pain Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.

The licensee failed to ensure that a resident, who was cognitively impaired, was assessed using the home's assessment tool when a new onset of pain was identified.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the pain management program provides communication and assessment methods for residents who are cognitively impaired and must be complied with.

Specifically, the home's pain management policy, stated each resident must have a daily formal pain assessment at significant condition changes.

Rationale and Summary
The home's pain policy stated that residents with cognitive impairment should have an Abbey Scale assessment completed daily for 7 days when a resident exhibits a change in health status.

A resident with cognitive impairment had a fall and had a suspected injury. An

Abbey Scale assessment was completed at the time, which stated that the resident was experiencing pain. There were no further pain assessments completed for the following days despite continuing to experience pain.

A registered staff stated that the resident continued to have pain on the following days and that pain assessments should have completed.

When a resident was not assessed for pain, they were at risk of having unrelieved pain.

Sources: Resident clinical record, interview with staff, home's pain management policy
[000686]

WRITTEN NOTIFICATION: Pain Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee failed to implement strategies to manage pain for a resident.

In accordance to with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there are strategies to manage pain and that they are complied with.

Specifically, the home did not comply with the home's pain management policy which stated that residents experiencing pain must be treated using pharmacological methods to maximize function and promote quality of life.

Rationale and Summary
A resident was identified to have been experiencing pain and there were no pain interventions implemented.

A registered staff stated that the resident was experiencing pain during a three day time period, and that no pain medication was administered.

When a resident did not receive medication for pain there was a risk of continued pain and discomfort.

Sources: Resident clinical record, Interview with staff, Home's pain management policy
[000686]

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that the monitoring of a resident of their behaviours using the home's Dementia Observation System (DOS) was fully documented.

Rationale and Summary
A resident was initiated on DOS monitoring due to an altercation with a co-resident. The resident's DOS data collection sheet had incomplete documentation on multiple shifts and times.

The DOC stated that the DOS collection sheet should have been fully completed.

Failure to complete the DOS data collection sheet of behavioural monitoring made it more challenging for the home to collect and analyze the information and determine patterns or triggers related to a resident's responsive behaviours.

Sources: Resident's DOS data collection sheet; Interviews with DOC and other staff. [000684]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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).

1) The licensee failed to implement the Standards, last revised September 2023, when staff did not support or encourage residents to perform hand hygiene (HH) prior to meals.

In accordance with the Additional Requirements in the IPAC Standard section 10.4 (h) staff are expected to provide support for residents to perform HH prior to receiving their meal.

Rationale and Summary
It was observed that HH was not offered to residents prior to meal service and no residents were observed completing HH prior to noon meal service or during the meal service.

The home's HH policy stated that hands of residents, staff, volunteers or family members are to be cleaned before assisting with meals or snacks.

The IPAC lead and other staff stated that HH was to be either completed or assisted for all residents before meals.

A resident stated they were not asked to complete HH and did not receive help to clean their hands before they ate.

When residents were not completing HH prior to meal service, there was a risk of transmission of infectious agents.

Sources: Observations, home's HH policy and interviews with a resident and staff.

2) The licensee failed to implement the Standard, last revised September 2023, when staff did not complete HH at the four moments of HH.

In accordance with the Additional Requirements in the IPAC Standard section 10.4 (h) staff are expected to perform HH, including, but not limited to, at the four moments of hand hygiene, before initial resident/resident environment contact.

Rationale and Summary

The homes Policy INF-04-02b Titled Hand Hygiene documented that hands of residents, staff, volunteers or family members are to be cleaned before assisting with meals or snacks, before preparing, handling or serving food or medications to resident and after contact with a resident or items in their immediate surroundings when leaving, even if the client/patient/resident has not been touched.

The following observations were completed in the home:

PSW #106 was pouring and providing drinks to residents and not completing HH.
PSW #107 did not complete HH after clearing dirty dishes and moving to clean dishes or prior to assisting a resident with their meal.
PSW #108 did not complete HH at anytime during meal service or when assisting residents with meals.
PSW #109 did not complete HH when providing meal service.
Registered Practical Nurse (RPN) #105 did not complete HH when administering medication.

When staff did not complete HH, there was a risk of transmission of infectious agents.

Sources: Observations, Home’s hand hygiene policy, and interviews a resident and staff.
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WRITTEN NOTIFICATION: Safe storage of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs were stored in a medication cart that was secure and locked.

Rationale and Summary
A medication cart was not locked and was left unattended by staff.

A registered staff stated that the medication cart should have been locked when left unattended.

When the medication cart was left unlocked and unattended, there was risk of residents accessing medications.

Sources: Observations and interviews with staff

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WRITTEN NOTIFICATION: Administration of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

The licensee failed to ensure that no resident administers a drug to themselves, unless the administration has been approved by the prescriber in consultation with the resident.

Rationale and Summary
Medications were left unattended with a resident.

A registered staff provided the resident with their medication at the table and did not remain with the resident.

The registered staff stated that best practice was to remain with the resident until the medication has been taken.

The registered staff stated there was nothing in place to allow for the resident to self administer medication.

The DOC stated that the policy was that registered staff remain with residents until their medication was taken, unless there was an order or directive for the resident to

self administer medication. The DOC stated that the resident did not have an order or directive to self administer medication.

The DOC stated that there was a risk to residents when medication were left unattended by Registered staff at resident tables.

Sources: Observations, resident clinical record, interviews with staff.
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