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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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347 rue Preston bureau 420
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 17, 2017	2017_621547_0007	025954-16, 032177-16, 003994-17, 011225-17	Critical Incident System

Licensee/Titulaire de permis

GEM HEALTH CARE GROUP LIMITED
470 RAGLAN STREET NORTH RENFREW ON K7V 1P5

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

GROVES PARK LODGE
470 RAGLAN STREET NORTH RENFREW ON K7V 1P5

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

LISA KLUKE (547)

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): June 12,13,14,15,16, 2017

The following critical incidents the home submitted were inspected:

Log#025954-16 related to a medication incident that involved a resident of the home,
Logs# 032177-16 and #011225-17 related to falls prevention, and
Log# 003994-17 related to an allegation of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Nursing Supervisor, an Office Manager, a Physiotherapy Assistant (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and family members.

In addition the inspector reviewed resident health care records and documents related to the Licensee's investigations into each critical incident, policies related to abuse and neglect, medication management and policies in the falls prevention program, education material provided to nursing care staff and manufacturers instructions for resident lift and slings utilized for residents in the home. The inspector observed aspects of resident care and interactions between residents and staff, along with medication administrations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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 O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used sling equipment and positioning aids

in accordance with manufacturers' instructions.

Resident #001 was admitted to the home on a specified date with several medical diagnoses. Resident #001's plan of care identified that the resident required a manual lift for all transfers. On a specified date, resident #001 fell from a sling utilized for a lift transfer while being transferred from bed to wheelchair. There were two PSW staff members present at the time of the lift transfer.

PSW #100 indicated to Inspector #547 that they positioned the six loop straps of the Prism Universal Sling to the carry bar hooks of the manual Prism lift as per their usual practice. PSW #100 indicated that the loops on the sling straps are stiff, and must have moved when the resident was elevated and suspended in the sling before the loop fell off the carry bar hook. PSW #100 was positioned to the resident's left side of the bed, while PSW #101 was positioned behind the prism lift to the right side of the residents bed in order to manoeuvre the prism lift and resident out of bed by the residents right side of the bed. PSW #100 moved to the foot of the resident's bed, out of hands reach of the resident once she was suspended in the prism sling to position the resident's wheelchair under where the resident was going to be lowered. When PSW #101 manoeuvred the resident away from the bed, was when the right mid loop strap of the prism sling migrated off the carry bar hook and the resident slipped to the floor to the resident's right side of the bed. PSW #100 indicated that both PSW's thought the loop straps were in place in the lift carry bar hooks, however the loop straps were not verified again once the resident was elevated from the bed and suspended by the sling. The right mid-torso loop strap of the Prism Universal Sling detached from the carry bar hooks on the manual lift after the resident was suspended in the lift sling, whereby resident #001 slipped out of the sling and fell to the floor. Resident #001 sustained a specified injury.

The manufacturers instructions were provided to Inspector #547 by the Clinical Nursing Supervisor on June 12, 2017. The Clinical Nursing Supervisor indicated a copy of these instructions is located in the nursing binders in the activity room for staff reference at all times. The Prism Medical sling used in the home called Prism Universal Sling Range identified by the Administrator to be in use in the home since 2008. The Administrator indicated that the nursing staff, including PSW #100 and #101 was provided training on June 10, 2008 as per the Licensee's education documentation. The Prism Universal Sling identified in the instructions that when hoisting from a lying position, the six straps should be attached to the carry bar hooks. The instructions further indicated to raise the carry bar just enough to tension the straps and ensure that the sling loops are still securely attached. The person can now be transferred as required.

PSW #100 and #101 did not follow the manufacturers instructions identified in the Prism Universal Sling instructions to verify the straps of the universal prism sling once the carry bar of the lift is raised just enough to provide tension by the resident's weight. This verification of the straps is required to prevent this incident whereby the mid loop strap migrated off the carry bar hook and resident #001 fell from the suspended sling to the floor and resident #001 sustained a specified injury. Resident #001 died five days later related to a significant change in the resident's health status after this incident. [s. 23.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Upon review of the home's medications incident reports, the following drugs were not administered to residents in accordance with the directions for use specified by the prescriber:

A. Resident #003 was admitted to the home on a specified date with several medical diagnoses. Resident #003 was prescribed a specified medication to be provided as needed for pain on a specified date and time. On this specified date, five hours later, the resident was provided a specified dose of this pain medication instead of the most recent orders as prescribed.

B. Resident #004 was admitted to the home on a specified date with several medical

diagnoses. Resident #004 was prescribed a specified pain medication for a specified degenerative joint disease, a specified antidepressant medication at bedtime to assist with sleep daily.

On a specified date, resident #004 was not provided these medications at bedtime as prescribed and the resident's medication incident report indicated the resident remained awake throughout the night. Further review of the resident's medication administration records and progress notes after this incident of missed medications and noted the following added medications were required following this medication incident. These medications were provided to the resident for headache, nausea and agitation issues with only moderate effect as the resident continued to wander with verbally responsive behaviour towards staff during the night.

C. Resident #005 was admitted to the home on a specified date with several medical diagnoses. Resident #005 was prescribed a specified medication at bedtime as a prophylactic method to prevent infections, another two specified medications at bedtime for agitation, and a medication for pain at bedtime. Resident #005 was not provided these medications on a specified date at bedtime as prescribed.

D. Resident #006 was admitted to the home on a specified date with several medical diagnoses. Resident #006 was prescribed specified medications at bedtime to manage pain and a condition of the digestive system. Resident #006 was not provided these medications on a specified date at bedtime as prescribed. Resident #006 required pain medication for complaints of pain to a specified body area to be administered after this incident of missed medications at bedtime.

On June 15, 2017 the Director of Care (DOC) indicated to Inspector #547 that she received each medication incident report, and reviewed the errors with the registered nursing staff members involved, and that they had not followed the Licensee's policy and procedures titled Administration of Medication #7, last revised December 13, 2016. The procedure in this policy stated the standard to be maintained during a medication pass #10: to prepare the resident's medications according to the orders in the home's Electronic Medication Administration Record (EMAR), to administer the medication to the resident and then document the medications administered on the EMAR for the corresponding date and time immediately for each medication administered to the resident. These incidents were noted that the resident's EMAR was signed however the medication pouches remained in the resident's medication drawers which indicated that

the Licensee's medication administration procedure was not followed.

As such, drugs were not administered to resident #003, #004, #005 and #006 in accordance for use as specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 20th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA KLUKE (547)
Inspection No. / No de l'inspection :	2017_621547_0007
Log No. / Registre no:	025954-16, 032177-16, 003994-17, 011225-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 17, 2017
Licensee / Titulaire de permis :	GEM HEALTH CARE GROUP LIMITED 470 RAGLAN STREET NORTH, RENFREW, ON, K7V-1P5
LTC Home / Foyer de SLD :	GROVES PARK LODGE 470 RAGLAN STREET NORTH, RENFREW, ON, K7V-1P5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Donna Pinkham

To GEM HEALTH CARE GROUP LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with section 23, to ensure actions are taken to protect residents from injury during lift transfers while utilizing Prism Universal Slings.

The plan must provide the following:

1.Outline the immediate steps taken to ensure resident safety with regards to lifts and transfers,

2.Include the provision of re-education to all nursing staff as it relates to the Prism Universal Sling manufacturers instructions,

3.Outline how the licensee will ensure the learning is acquired and integrated into the day-to-day practice of nursing staff with the use of the Prism Universal Slings for ongoing monitoring of compliance,

4.Outline how routine and spontaneous audits of nursing staff utilizing the Prism Universal Slings during lift transfer and their techniques by Registered Nursing Staff on all shifts are reviewed and revised for re-education needs.

This plan must be submitted in writing to Inspector Lisa Kluke by fax at 613 569-9670 on or before July 24,2017.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used sling equipment and positioning aids in accordance with manufacturers' instructions.

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This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 11, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Kluke

Service Area Office /
Bureau régional de services : Ottawa Service Area Office