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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2015	2015_299559_0009	T-1672-15	Resident Quality Inspection

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

ANN HENDERSON (559), BARBARA PARISOTTO (558), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 16, 17, 20, 21, 22, 23, 24, 27, 28 and 29, 2015.

During the course of the inspection, the following complaint and critical incident inspection was completed: T-1595-14

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), assistant director of care (ADOC), manager of environmental services (ESM), manager of human resources (HR), registered dietitians (RD), dietary aides (DA), food service manager (FSM), registered staff, personal support workers (PSW), housekeeping staff, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
2 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Record review revealed resident #13 is incontinent of bladder and bowel.

The written plan of care reveals the resident is on an incontinent program and is to be toileted before meals, after meals and at night. The resident is also on the nursing rehabilitation program and there is an intervention which indicates the resident is to receive assistance for bowel care every day and as required.

A PSW revealed the resident is not on a toileting schedule for his/her bladder but is on a schedule for bowel care. Two registered staff members revealed the resident is on a toileting schedule. The nursing rehabilitation nurse revealed the resident prefers to use the continence product and PSWs stated he/she is not toileted before and after meals and at night.

An interview with the DOC confirmed the directions given for continence care are not clear for staff providing care. [s. 6. (1) (c)]

2. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan of care.

Record review revealed resident #38 has had a weight gain of 16kg in the last eight months.

On an identified date, resident #38's power of attorney for care (POA) raised concerns about his/her family member's weight gain. As a result the resident was to be offered fruit for the evening snack instead of sugary snacks.

On an identified date, the RD received a referral related to the POA's ongoing concern with resident #38's weight gain of 16kg in the last eight months. A plan was put in place for the resident whereby staff were directed to provide a reducing diet in small portions and fruit for snacks.

On an identified date, during lunch an identified PSW gave an extra portion of dessert to the resident. A dietary aide informed the PSW the resident was not to receive extra portions and was on a reducing diet. The PSW continued to give the second helping of dessert to the resident and said it was fine.

An interview with the RD confirmed the resident is on a reducing diet and staff had not provided care as set out in resident 38's nutritional plan of care. [s. 6. (7)]

3. Record review revealed resident #39 is on a high calorie and protein diet with added fortified oatmeal and nutritional supplement at lunch. Staff are to provide and offer a small yogurt at the end of each meal.

On an identified date, at the end of lunch the resident was not offered a small yogurt. A dietary aide confirmed the resident is not offered a small yogurt after each meal.

An interview with the RD confirmed the resident is to be offered a small yogurt and staff had not provided the care as specified in resident #39's nutritional plan of care. [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 to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policies and procedures relating to nutrition care are implemented.

A review of the policy Weight Monitoring/Resident Weight revised in October 2013, indicates the following:

- By the 5th of the month all residents must be weighed, unplanned weight change identified and a referral to Dietitian completed for any resident with confirmed loss/gain of >2kg or 5%, 7.5% or 10% or any other weight change that compromises a resident's health status. The referral is done in PointClickCare (PCC) under the assessment tab.

A record review revealed, resident #10 experienced a 7.5% weight loss, from 72kg to 66.4kg reflecting a 5.6kg weight loss over three months.

A record review of the assessment tab and an interview with the RD confirmed a referral for significant weight loss for resident #10 was not completed as per the Weight Monitoring/Resident Weight policy in March 2015. [s. 68. (2) (a)]

2. A record review revealed, resident #7 experienced a 7.9% weight loss, from 59kg to 54.3kg reflecting a 4.6kg weight loss over one month.

A record review of the assessment tab and interviews with a RPN and the RD confirmed a referral for significant weight loss for resident #7 was not completed, as per the Weight Monitoring/Resident Weight policy. [s. 68. (2) (a)]

3. A record review revealed, resident #6 experienced a 10% weight loss, from 60.6kg to 53.8kg reflecting a 6.8kg weight loss over five months.

A record review of the assessment tab and interview with the RD confirmed a referral for significant weight loss for resident #6 was not completed as per the Weight Monitoring/Resident Weight policy in March 2015. [s. 68. (2) (a)]

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 the policies and procedures relating to nutrition care are implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On an identified date, the inspector observed and heard a PSW speak over resident #38's head at the dining table, to a dietary aide and state, "I'm giving him/her more because he/she's hungry and just like children we give them more. It's fine".

After the meal service, the DA stated he/she did not like hearing a staff member referring to the residents as children.

An interview with the RD confirmed referring to the resident as a child is disrespectful. The administrator confirmed the home has suspended an employee pending an investigation and the DOC immediately reminded staff of the resident's rights; where every resident has the right to be treated with courtesy, respect and dignity. [s. 3. (1) 1.]

2. The licensee failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On an identified date, at approximately 10:40 a.m. the inspector observed resident #10 and at 11:40 a.m. observed another resident, being provided foot care in the lounge.

An interview with an RPN confirmed foot care is to be provided in the resident's room and providing foot care in the lounge infringed on the residents' right to privacy in treatment. [s. 3. (1) 8.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Record review revealed resident #12 was diagnosed with a respiratory condition. On an identified date, the resident had an elevated temperature of 38.3 degrees celsius and an order for antibiotics was received. The nurse practitioner ordered a repeat chest x-ray. Record review revealed the resident had vital signs including oxygen saturation taken on every shift.

Review of policy INF-02-01 Surveillance and staff interviews revealed residents with symptoms are tracked and recorded each day on the monthly line list and signed by the registered staff for days, evenings and nights. The line list identifies residents with symptoms, the diagnostic tests ordered or performed and treatments started.

The line list for an identified home area, was partially signed and had no documentation for resident #12's symptoms.

The ADOC confirmed the line list should have been completed by the registered staff. [s. 8. (1)]

2. A review of the home's policy titled "Falls Prevention Program", policy number: NUR-03-16, revised May 2014, indicated if a resident has three or more falls over a thirty-day period, a falls referral in PCC should be completed by the falls prevention coordinator in collaboration with the physiotherapy, restorative care, nursing rehabilitation, dietary, housekeeping and life enrichment departments. This is to ensure interventions are in place and beneficial to the resident.

Record review revealed resident #9 is at risk for falls and he/she fell on four occasions.

A review of the fall referrals and an interview with a registered staff member confirmed no fall referral had been completed in PCC by the falls prevention coordinator for resident #9 for the above mentioned falls.. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that furnishings are maintained in a good state of repair.

a) On an identified date, the inspector observed a missing grab bar and four small holes in the wall next to the toilet in a resident's room.

Interviews with housekeeping staff and two nursing staff revealed there was a grab bar on the wall and it has been missing for at least six months. The housekeeping staff further confirmed a few months ago, he/she sent a work order to maintenance department for repairing the grab bar.

b) On an identified date, the inspector observed in a resident's bathroom, a two foot length of laminate trim had peeled off from the edge of the bathroom vanity unit.

An interview with a housekeeping staff indicated the bathroom vanity had been damaged for two months and he/she was not aware if anyone had reported the damage to the maintenance department.

An interview with the ESM confirmed a work order was received for repairing the grab bar in the resident's bathroom on an identified date, and the ESM was not aware the bathroom vanity in the resident's bathroom was damaged. The ESM further confirmed the grab bar and bathroom vanity are not maintained in a good state of repair and should be fixed. [s. 15. (2) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure there was appropriate seating for staff who are assisting residents to eat.

During a dining observation on an identified home area on an identified date, a PSW was standing and assisting two residents with their meal at one table and then went to a different table and stood to assist a third resident.

A RPN stated, it is the expectation PSWs will sit when assisting residents during meal service but there are not enough stools available. In the adjoining activity room there were three chairs available and the inspector observed another staff member locate a chair from this room to assist a resident during the meal service. [s. 73. (1) 11.]

Issued on this 12th day of May, 2015

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

Original report signed by the inspector.