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

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
Jan 22, 2016	2016_168202_0002	013523-15	Critical Incident System

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

VALERIE JOHNSTON (202)

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): January 18, 19, 2016.

During the course of the inspection, the inspector(s): reviewed clinical records.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), registered nursing staff and personal support workers.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

- **1 WN(s)**
- **1 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. (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 the care set out in the plan of care is provided to the resident as specified in the plan.

A review of the written plan of care for resident #001 directed staff to provide two staff physical assistance for all transfers. The resident required verbal instruction and cueing related to appropriate foot placement and when to sit safely.

A review of resident #001's progress notes and Critical Incident Report (CIS) that had been submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, revealed that on an identified date, the resident fell while under the assistance of one staff member. As a result of the fall, the resident sustained an injury that required hospitalization and surgical intervention.

An interview with PSW #102 revealed that on an identified date, he/she assisted resident #001. PSW #102 indicated that he/she transferred resident #001 by him/herself out of the wheelchair and onto the toilet. The PSW further indicated that he/she also transferred the resident off the toilet without another staff present. The PSW stated that during the resident's transfer off the toilet, the resident fell to the floor.

Interviews with RPN #100, PSW's #100, #101, #102, #103 and #104 indicated that resident #001 was always to be transferred with two staff assisting. Two staff must be present at all times during the resident's transfer and care, including toileting.

The above mentioned staff further indicated that every resident's transfer status is written in the plan of care and that there are two signs posted in every resident room, both in the washroom and above the resident's bed, illustrating the transfer status of the identified resident.

PSW #102 confirmed in an interview that he/she was aware that resident #001 required two staff assistance before transferring the resident on the identified date. PSW #102 indicated that he/she transferred resident #001 without another staff member anyway because the resident required toileting assistance.

An interview with the DOC confirmed that PSW #102 had transferred resident #001 by him/herself and without another staff member present on the identified date. The DOC further confirmed that PSW #102 had not provided resident #001 with the care as specified in the resident's plan of care, resulting in injury to the resident. [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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 25th day of January, 2016

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

Original report signed by the inspector.