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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 22, 2018 | 2018_414110_0002 | 028821-16, 029740-16 | Complaint |

## 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

DIANE BROWN (110)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): January 24, 25, 26, 30, 31, 2018. February 1, 2, 5, 2018.**

**During this inspection a complaint, and an associated Critical Incident was inspected related to allegations of staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Interim Director of Care, Registered Nursing Staff, Resource Nurse, Personal Support Workers, Substitute Decision Makers (SDM/POA) for residents.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 the care set out in the plan of care is provided to the resident as specified in the plan.

A complaint was submitted to the Ministry of Health and Long Term care on an identified date, related to incidents of altered skin integrity, of unknown origin.

Record review identified that resident #001 had responsive behaviours associated with their diagnosis.

Resident's written plan of care identified the individualized care needs for resident #001.

An interview with registered nurse #121 confirmed that resident #001 had responsive behaviours related to their diagnosis and that external resources were accessed to develop a plan of care. Staff #121 confirmed the individualized care needs for resident #001 as identified in the written plan of care.

An interview was held with PSW #115 who identified and described resident #001's responsive behaviours. Further interviews were held with PSW #116, #117 and #118 who consistently identified and described resident #001's behaviours.

An interview was held with PSW #122 and #117. Staff interviews along with a record review identified that on an identified date PSW #122 and #117 provided care to resident #001. Interviews and a review of records identified that the plan of care was not followed during the identified care.

An interview with registered nurse #121 confirmed that the manner in which care was provided to resident #001 on the identified date would not have achieved the desired outcome for the resident and that the plan of care was not followed. [s. 6. (7)]

2. Record review of the progress notes identified an entry of altered skin integrity of unknown origin by RPN #123 on an identified date and that the resident's SDM was concerned.

Interviews with PSW staff #115, #120, #118, #122 and #117 identified that during morning and evening care staff are required to complete a skin observation and report the observation under the skin observation task in Point of Care (POC) and report to the registered staff as necessary.

Record review identified the "task" of a skin observation in resident #001's plan of care. A review of care documentation on an identified date revealed that PSW #122

documented care provided, but a skin observation was not included.

Interviews with PSW #122 and #117 who provided the identified care to resident #001 on the identified date, revealed that they had not observed any area of altered skin integrity on resident #001's. However, PSW #122 who documented resident #001's care confirmed that they had not completed a skin observation task on Point Click Care (POC) and could not confirm if a skin observation had been completed as the resident had responsive behaviours during care.

A review of the home's Skin and Wound policy #Nur-05-05, created May 2008 included direction to PSWs to complete a skin observation on each shift, document any redness, rash etc., in POC and notify the registered staff.

An interview with the interim Director of Care confirmed that a skin observation was part of the resident's plan of care and that on the identified shift and date, the plan of care was not followed. [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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately.

A complaint was submitted to the Ministry of Health and Long Term care on an identified date, related to incidents of altered skin integrity, of unknown origin.

Record review of progress notes identified PSW #115 documented on an identified time and date, that they noticed an area of altered skin integrity on resident #001 which had not been there the night before and reported the area to RPN #119 on duty. Further record review identified documentation by RPN #119. The documentation revealed that resident had areas of altered skin integrity, of unknown origin, and that the RN on duty and the resident's SDM were notified.

An interview was held with PSW #115, who confirmed they had worked on the identified date, when an area of altered skin integrity was identified on resident #001 by a visitor. PSW #115 revealed that they had spoken with the resident's visitor and that the visitor was concerned. The PSW stated they forwarded the concern to RPN #119.

An interview with RPN #119 revealed that when they entered resident #001's room to administer medication a visitor of the resident was present and the visitor seemed concerned and pointed to an area of altered skin integrity on resident #001. The RPN stated they followed up by calling the RN on duty, RN #105 and the resident's SDM.

An interview with RN #105 identified they had no recollection of the resident's area of altered skin integrity or of being contacted by RPN #119.

Review of the home's complaint binder failed to identify the concern expressed by resident #001's visitor on the identified date. The administrator confirmed that management had not been made aware of this concern or resident #001's area of altered skin integrity consequently there was no follow-up investigation or response provided within 10 business days of receipt of the complaint from the visitor on the identified date. [s. 101. (1) 1.]

***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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately, to be implemented voluntarily.***

---

**Issued on this 26th day of March, 2018**

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

**Original report signed by the inspector.**