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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 9, 2019	2018_565647_0035	001976-18, 005804-18, 007493-18, 020848-18, 030524-18, 032388-18	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

JENNIFER BROWN (647)

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): December 10 - 14, and 18 - 20, 2018

The following intakes were completed in this Critical Incident System (CIS) Inspection:
-one related to staff to resident abuse/neglect,
-one related to an unexpected death,
-one related to an Acute Respiratory Infection (ARI) outbreak,
-three related to a fall that resulted in a transfer to hospital.

A Follow Up Inspection #2018_565647_0034 was conducted concurrently with this CIS Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistance Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Restorative Care Coordinator, Nursing Rehabilitation Coordinator, Residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector conducted observations in resident home areas, and care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

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

- **3 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	Légende 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the substitute decision maker (SDM), if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A Critical Incident System (CIS) report was received by the Director for the unexpected death of resident #001.

A review of the plan of care which included the progress notes for resident #001 identified a consent for a personal assistance device had been signed by the SDM of resident #001. The consent indicated that resident #001 had been able to use this device for an identified act of daily living.

A review of policy titled "Personal Assistance Service Device (PASD)", Policy #NUR-05-16 and NUR 03-21, last revision date of November 2017, stated "Obtain and record informed consent (including that the risks and benefits of alternative treatment option and risks and benefits related to the use of the PASD have been outlined to the resident/SDM".

During an interview with the SDM, they acknowledged signing the consent form for the

personal assistance device; however, did not recollect being informed or any discussion related to any risks associated with the use of the device.

Together with the Director of Care (DOC), a record review had been completed of resident #001's progress notes, related assessments, and plan of care. During this review there had been no evidence to indicate that the risks and benefits related to the use of the personal device had been discussed with either the SDM or resident #001. [s. 6. (5)]

2. The licensee has failed to ensure that residents were reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A CIS report was received by the Director for the unexpected death of resident #001. See WN #1, finding one for additional information.

A review of the current written plan of care indicated that resident #001 had a specific focus of an identified risk with specific interventions.

During observations of resident #001's photos of the incident, it was discovered that the specific interventions that had been identified on the current written plan of care had not been in place.

During interviews with direct care staff members #102, #108, and Registered staff members #103, #105 and #107, they all indicated that the interventions that were in the written plan of care for resident #001 had been initiated as an identified strategy. These staff members further indicated that they were not sure when the interventions had changed; however, confirmed that they were not current interventions.

Together, Inspector #647 and the DOC reviewed resident #001's most recent care plan and identified that the plan of care for resident #001's had not been revised with current interventions. [s. 6. (10) (b)]

3. A CIS report was received by the Director which indicated that resident #004 had a fall that resulted in a transfer to hospital.

The CIS report further indicated that resident #004 had been in a specific location, fell, and sustained an injury. The resident had been assessed at the home and transferred to

the hospital for further assessment and treatment.

A review of the current written plan of care indicated that resident #004 had an identified focus of a specific risk with associated interventions to be in place.

During multiple observations of resident #004, it was observed that the identified associated interventions had not been in place as the written plan of care stated.

During interviews with direct care staff member #109, #111, and Registered staff member #110, they all indicated that the interventions that were in the written plan of care for resident #004 had been initiated as identified strategies as resident #004 lacked the insight to know that they were at an identified risk. These staff members further indicated that they were not sure when the interventions had changed, however confirmed that they were not current interventions.

Together, Inspector#647 and the DOC reviewed resident #004's most recent care plan and identified that the plan of care for resident #004's had not been revised with current interventions. [s. 6. (10) (b)]

4. A CIS report was received by the Director which indicated that resident #006 had a fall that resulted in a transfer to hospital.

The CIS report further indicated that staff responded to resident #006 calling out and observed resident #006 in a specific location. There had been a specific intervention in place; however, the resident had not utilized it. The resident had been assessed at the home and transferred to the hospital for further assessment and treatment where they had been diagnosed with an identified injury.

A review of the current written plan of care indicated that resident #006 had an identified risk with specific interventions in place.

During multiple observations of resident #006, it was identified that the specific interventions that had been observed at the time of the incident had not been identified in the written plan of care.

During interviews with direct care staff members #109, #111, and Registered staff member #110, they all indicated that the interventions that were in the written plan of care for resident #006 had been initiated as specific strategies as resident #006 lacked

the insight to know that the were at a specific risk. These staff members further indicated that they were not sure when the interventions had changed, however confirmed that they were not current interventions.

Together, Inspector#647 and the DOC reviewed resident #004's most recent care plan and identified the plan of care for resident #006's had not been revised with current interventions. [s. 6. (10) (b)]

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 resident, the SDM, if any, and the designate of the resident/SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care and to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

Neglect is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as a "failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A CIS report was submitted to the Director, in response to resident #011 reporting an allegation of neglect from an identified staff member from a specific shift.

A review of resident #011's health care record, indicated they had been found to be lying in soiled linen. Resident #011 indicated to staff that they used their call bell multiple times during a specific shift and no staff responded. Resident #011 further indicated that when a staff member did respond they directed resident #011 to not use their call bell and to urinate in their incontinent product instead.

A review of the home's investigation of the incident indicated that the home interviewed resident #011 upon being made aware of the allegation of neglect. The home's investigation notes indicated that resident #011 rang the call bell during the identified shift and direct care staff member #115 stated "you don't have to put your buzzard on because we are not going to service you. We are not going to bring the commode to you anymore, you can pee in your diaper and I will get to you later". The resident continued to explain that they eventually had to urinate in their incontinent product and when they woke up, they were humiliated and soaking wet.

The Resident Assessment Instrument Minimum Data Set (RAI-MDS) indicated the resident's cognition was intact.

During an interview with resident #011, they indicated that they had no recollection of the incident; however, confirmed that they use the call bell to request assistance from staff.

Direct care staff member #115 had been unavailable to speak with the Inspector at the time of the inspection.

In an interview with direct care staff member #102 who had provided morning care to resident #011, they indicated that resident #011's clothing and bed linen were soiled and resident #011 was emotionally distraught and tearful.

During an interview with Registered staff member #112, they indicated that when they arrived on the home area at the beginning of their shift, they observed direct care staff member #115 sleeping at the nursing station and further indicated that there were many beds that had been observed with soiled linen and residents with saturated incontinent products.

In an interview with the DOC, they indicated that direct care staff member #115 had been relieved from their duties until the investigation concluded. The DOC further indicated to Inspector #647 that once the investigation had concluded, the allegation of neglect to resident #011 had been verified and direct care staff member #115 received disciplinary action. [s. 19. (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 residents are protected from abuse by anyone, and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee make a report in writing to the Director of any of the incidents described in r. 107 (1), (3) or (3.1), within 10 days of becoming aware of the incident, that includes a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

The home submitted a CIS report to the Director on a specific date to report an incident with resident #004 that resulted in injury and transfer to hospital.

The home received a request from the Director via the electronic CIS report two days after the original submission to request additional information which included: resident's status upon return from hospital and any injuries sustained, transfer and ambulatory status prior to the specific incident and any interventions that were in place prior to the specific incident and long term actions planned to prevent recurrence.

The Director further placed a phone call to the home 17 days after the original submission to request the CIS report be amended to include the information that had originally been requested 15 days prior.

During an interview with the DOC they indicated that they or their designate are responsible to ensure that all CIS reports are submitted and amended as per the legislative timelines and requirements.

During this interview, the DOC acknowledged that the CIS report as mentioned above was not amended until 18 days after the original submission, which had been outside of the timelines as per the required legislation. [s. 107. (4) 1.]

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Issued on this 10th day of January, 2019

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

Original report signed by the inspector.