Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: February 27, 2023	
Inspection Number: 2023-1433-0001	
Inspection Type: Critical Incident System	
Licensee: Grove Park Home for Senior Citizens	
Long Term Care Home and City: Grove Park Home For Senior Citizens, Barrie	
Lead Inspector Jennifer Nicholls (691)	**Inspector Digital Signature** Jennifer J Nicholls Digitally signed by Jennifer J Nicholls Date: 2023.03.03 15:26:21 -05'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): January 16-20, 2023

The following intake(s) were completed during this inspection:

Three intakes related to fall with injury; One Intake related to allegation of staff to resident abuse; One Intake related to allegation of physical abuse by a resident; One Intake related to an unexpected death of a resident.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee has failed to ensure that the allegation of staff to resident abuse was immediately reported to the Director.

Summary and Rationale

An incident was reported by a staff member and was not reported to the Director immediately. In interview with the Director of Care (DOC), they indicated that the incident should have been reported to the Director, using the After-Hours line.

There was low risk of harm by this incident not being immediately reported to the Director.

Sources: Critical Incident (CI) Report; internal investigation notes; licensee policy titled "Zero Tolerance for Resident Abuse and Neglect"; interview with DOC, and other staff.

[691]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee has failed to protect a resident from abuse by anyone.

Summary and Rationale

O. Reg 79/10 of the LTCHA, 2007, had defined verbal abuse as "any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self

worth made by anyone other than a resident. Verbal abuse also includes any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences."

An incident was reported that occurred involving a resident and the internal investigation notes indicated that an allegation was founded. In an interview with the (DOC), they indicated that the staff member did not follow the abuse policy.

There was minimal risk of harm to the resident.

Sources**:** CI report; internal investigation notes; licensee policy titled "Resident Abuse, Policy #PER-RE-01"; interview with DOC and other staff.

[691]

WRITTEN NOTIFICATION: Post Fall Assessment

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 49 (2)

The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Summary and Rationale

A CI was submitted to the Director related a fall with injury**.** The health care records for the resident were reviewed and a post-fall assessment tool was not found. An Interview with a staff member confirmed that post fall assessment is required after a resident has had a fall. The DOC confirmed that the post-fall assessment tool had not been completed as per the homes' policy after the resident's fall with injury.

There was moderate risk to the resident whose post falls assessment was not completed.

Sources: "Falls Prevention Program, policy NUR-05-11" last reviewed January 2020, the Resident's health care records, CI Report; interviews with staff and the DOC.

[691]

Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965