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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: January 10, 2024
Inspection Number: 2023-1433-0004
Inspection Type: Complaint Critical Incident
Licensee: Grove Park Home for Senior Citizens
Long Term Care Home and City: Grove Park Home For Senior Citizens, Barrie

Lead Inspector	Inspector Digital Signature
Gabriella Del Principe (741734)	Gabriella Del Principe Digitally signed by Gabriella Del Principe Date: 2024.01.29 09:53:09 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 18-22, 28, 2023.

The following intake was inspected in this Critical Incident (CI) inspection:

- Intake #00101925 was related to staff to resident abuse

The following intake was inspected in the Complaint inspection:

- Intake #00102871 was related to concerns regarding hot water temperatures

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Housekeeping, Laundry, and Maintenance Services
Infection Prevention and Control

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee failed to ensure that a resident was afforded privacy during care.

Rationale and Summary

A staff member informed the home that a resident was provided care by another staff member in a manner that lacked privacy.

During the home's investigation, the staff member confirmed that they had performed care for the resident in this manner.

Failure to provide the resident with privacy prevented them from receiving care in a dignified and respectful manner.

Sources: Interview with staff members, and the critical incident investigation notes. [741734]

WRITTEN NOTIFICATION: Reporting to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report to the Director incidents of alleged, suspected or witnessed abuse or neglect of a resident.

Rationale and Summary

Staff members brought forward their concerns regarding another staff member's interaction and care towards multiple residents, that occurred over a period of time.

Once the home became aware of the concerns, an investigation was conducted.

The home submitted a critical incident to the Director the following week.

Failure to inform the Director immediately of any incidents in which there were reasonable grounds to suspect abuse or neglect towards a resident had occurred, may have prevented the Director from responding accordingly and in a timely manner.

Sources: Critical incident report, critical incident's investigation notes, staff member

personnel file, and interview with a staff member. [741734]

WRITTEN NOTIFICATION: Bathing

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that a resident's bathing needs were met, when a home area experienced hot water issues.

Rationale and Summary

Concerns regarding the temperature of the hot water in a home area were identified, due to mechanical equipment failure.

After reviewing a resident's clinical health records, it was documented on two dates that the resident was not provided a bath or bed bath as the water was too cold, which was upsetting for the resident. In the following days, the resident was provided a bath as per the home's contingency plan.

Interviews with staff members demonstrated gaps in the communication and collaboration once the hot water issues were first identified.

Failure to ensure adequate communication and collaboration among all staff members once the hot water issues were first identified prevented the resident's

bathing needs from being met at that time.

Sources: Resident's clinical health records, interview with staff members. [741734]

WRITTEN NOTIFICATION: Routine / Preventative Maintenance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The licensee failed to ensure that daily routine and preventative maintenance checks were completed.

Rationale and Summary

Concerns regarding the mechanical equipment that boosted the hot water temperature in one home area was identified.

Staff were to complete a daily check of all equipment within the home, interior and exterior, as per the home's procedures, to ensure that all equipment is in good working order. Additionally, the home conducted a biannual preventative maintenance inspection which was completed by a third party.

Records demonstrated that the most recent biannual preventative maintenance inspection was completed October of 2023. However, the daily preventative maintenance check of all the equipment in the home had not been consistently

completed or documented.

Failure to monitor all equipment in the home daily could prevent early detection of mechanical or equipment issues, that could have the potential to impact resident care.

Sources: Interview with staff members, record review of the daily preventative maintenance checklist and the scheduled preventative maintenance inspection work order. [741734]

WRITTEN NOTIFICATION: Water Temperatures

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 96 (2) (k)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

The licensee failed to ensure that water temperatures were monitored once per shift in random locations where residents had access to hot water.

Rationale and Summary

Concerns regarding the temperature of the hot water in one home area was identified.

Staff members indicated that maintenance staff and nursing staff were to monitor

the water temperatures daily; maintenance staff were to monitor water temperatures during the day, and nursing staff were to monitor water temperatures on the evenings and nights.

A review of the Water Temperature Tracking Forms, from October to December 2023, demonstrated that water temperatures were not consistently taken and recorded.

Failure to consistently measure and record hot water temperatures in areas where residents have access prevented accurate water temperature tracking during the time in which the home area experienced hot water issues.

Sources: Interview with staff members, and record review of "Water Temperature Tracking Form". [741734]

WRITTEN NOTIFICATION: Critical Incident Report-Individuals Involved in the Incident

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (5) 2. i.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) 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:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,

The licensee failed to include the names of all residents involved in an incident, within the critical incident submitted to the Director.

Rationale and Summary

Staff members brought forward their concerns regarding another staff member's interaction and care towards multiple residents, that occurred over a period of time.

The home submitted a critical incident regarding the allegations of abuse and improper care and an investigation was conducted. A review of the critical incident and the home's investigation notes demonstrated that three resident's names were not included within the critical incident report.

Failure to include all of the resident names within the critical incident report prevented the Director from accurately assessing the level of risk at the time that the critical incident was submitted, and from responding accordingly.

Sources: Critical incident report, critical incident investigation notes, interview with a staff member. [741734]