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
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: February 27, 2024

Inspection Number: 2024-1433-0001

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**
Alicia Campbell (741126)	Alicia Campbell Digitally signed by Alicia Campbell Date: 2024.02.29 15:36:09 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12-15, 20-23, 2024

The following intake(s) were inspected:

- Intake #00105470, CI #2950-000001-24 - related to injury of a resident of unknown cause
- Intake #00106153 - complaint related to lack of communication and care of a resident

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs were stored in a medication cart that was secure and locked.

A medication cart was observed unattended and unlocked on a unit. A Registered Practical Nurse (RPN) stated the medication cart should not have been unlocked. The RPN locked the medication cart.

Sources: observation; interview with RPN.

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Date Remedy Implemented: February 21, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
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.

a) The licensee has failed to ensure that a resident's substitute decision maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A new skin alteration was identified on a resident. The resident's substitute decision maker (SDM) was not informed of this skin alteration until nine days later, from another family member who was visiting the resident.

The Skin and Wound Lead indicated a residents SDM should be informed of a new wound on the shift the wound was identified.

Failure of the home to inform the resident's SDM of their new skin alteration inhibited the resident's SDM of fully participating in the resident's care.

Sources: resident's progress notes; interviews with staff.

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b) The licensee has failed to ensure that a resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
A new skin alteration was identified on a resident. The resident's substitute decision maker (SDM) was not informed of this skin alteration until two days later.

The Director of Care (DOC) indicated that registered staff are supposed to inform residents SDM's of any new injury. A Registered Nurse (RN) indicated the resident's SDM should have been informed of their new skin alteration.

Failure of the home to inform the resident's SDM of their new skin alteration may have inhibited the resident's SDM of fully participating in the resident's care.

Sources: resident's progress notes; interviews with staff.

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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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 has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred immediately reported the suspicion and the information upon which it was based to the Director. Pursuant to s.154 (3), the licensee is vicariously liable for a staff member failing to comply with subsection 28 (1).

Rationale and Summary
During an assessment, a resident stated an allegation of abuse to a staff member.

A Registered Nurse (RN) stated that they were never informed of this allegation and that it was a reportable abuse claim. The Director of Care (DOC) stated that this should have been investigated and reported to the Director.

The failure to report the alleged abuse of a resident immediately delayed the home's ability to investigate the allegations. The failure of the home to report this incident may have delayed the Director in responding to the incident.

Sources: resident's progress notes; interviews with staff.
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WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that when a resident exhibited altered skin integrity, they received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Rationale and Summary
A Personal Support Worker (PSW) noticed a new skin alteration on a resident and informed the nurse. Documentation shows that this skin tear was not treated until approximately 19 hours later by a Registered Practical Nurse (RPN).

The Skin and Wound Lead indicated the resident did not receive immediate treatment or interventions for this skin alteration.

Failure of the home to immediately treat the resident's skin alteration put the resident at risk of delayed healing and infection.

Sources: resident's clinical documents; interviews with staff.

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WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that when a resident exhibited altered skin integrity, it was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A resident presented with a new skin alteration. A weekly skin assessment was not completed for this skin alteration. Review of the homes skin and wound policy showed no direction on how to monitor outcomes for skin tears.

The Skin and Wound Lead stated that all skin tears should be monitored weekly with a skin and wound note that included the size of the wound and monitoring the wound for infection. The resident's skin alteration did not have a weekly skin note completed but should have.

Failure of the home to complete a weekly reassessment of a resident's skin alteration put the resident at risk of delayed healing and infection.

Sources: resident's clinical documents; interviews with staff.

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