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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Aug 29, 2018	2018_741178_0015	018351-18	Critical Incident System

Licensee/Titulaire de permis

Gem Health Care Group Limited
470 Raglan Street North RENFREW ON K7V 1P5

Long-Term Care Home/Foyer de soins de longue durée

Groves Park Lodge
470 Raglan Street North RENFREW ON K7V 1P5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN LUI (178)

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): July 20, 24, 2018.

This inspection involved Critical Incident Intake #018351-18, based on Critical Incident Report #2646-000004-18, regarding an allegation of sexual abuse of a resident.

During the course of the inspection, the inspector(s) spoke with residents, a family member of a resident, the Administrator, the Director of Care, a Physician, Registered Nurses (RNs), Personal Support Workers.

During the course of the inspection, the Inspector also observed residents and resident care, reviewed resident health records and home records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Legendé 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

During an interview with Inspector #178 on July 19, 2018, the Director of Care (DOC) indicated that as per resident #001's progress notes, the resident had experienced some bleeding from an identified area beginning on an identified date, and has continued to bleed small amounts intermittently.

The inspector reviewed resident #001's progress notes which indicated that the identified bleeding was first observed by staff on an identified date. A progress note on the identified date, indicated that registered nursing staff would monitor the bleeding and that the physician would be informed. Subsequent progress notes indicated that the resident was monitored for bleeding, and that bleeding or discharge was observed on six subsequent dates during the next month. The progress notes also indicated that resident #001's physician assessed the resident approximately one month after the bleeding was first observed by staff, and found scant pink discharge from an identified area.

During an interview with inspector #178 on July 20, 2018, Physician #106, who is resident #001's attending physician, indicated that nursing staff informed them of resident #001's bleeding by phone, approximately one month after the bleeding was first observed by staff. Physician #106 indicated that nursing staff communicates non-urgent resident problems by writing them on a sheet on the Doctor's Board, and that on review, Physician #106 found a notation regarding resident #001's identified bleeding on the Doctor's Board sheet dated one month after the bleeding was first observed by staff.

Inspector #178 reviewed the Doctor's Board sheets for two identified months. No documentation regarding resident #001's identified bleeding was present on the Doctor's Board sheet until approximately one month after resident #001's bleeding was first observed by staff.

During an interview with Inspector #178 on July 24, 2018, the DOC indicated that it is the registered nursing staff's practice to communicate non-urgent concerns to the physicians by writing them on the Doctor's Board. The DOC indicated that when RN #107 documented in resident #001's progress notes on an identified date that the physician

would be informed of resident #001's identified bleeding, RN #107 should have also documented the concern on the Doctor's Board at that time, but did not.

In conclusion, the licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other in the assessment of the resident, so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

Issued on this 28th day of September, 2018

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

Original report signed by the inspector.