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

# Public Report

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| **Report Issue Date:** August 22, 2025 |
| **Inspection Number:** 2025-1433-0005 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** Grove Park Home for Senior Citizens |
| **Long Term Care Home and City:** Grove Park Home For Senior Citizens, Barrie |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14, 15, 18, 19, 20 and 22, 2025

The following intake(s) were inspected:

- Intake #00150541 and Intake #00150568 related to Outbreaks.
- Intake #001448445 related to Falls prevention and management

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

Infection Prevention and Control
Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Infection Prevention and Contro

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)**
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

As per Additional Requirement 9.1 (b) of the IPAC Standard (April 2022, revised September 2023), staff must follow Routine Practices, including performing hand hygiene at the four moments.

A staff was observed administering medications to multiple residents without performing hand hygiene between interactions, including after handling body fluids during a blood sugar check.

Failure to follow hand hygiene protocols increases the risk of infection for both residents and staff.

**Sources:** Observation, IPAC Standard (revised September 2023), and interviews with Staff and IPAC Lead.

## WRITTEN NOTIFICATION: Infection Prevention and Contro

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)**
Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee failed to ensure that daily monitoring for symptoms indicating the presence of infection for a resident was completed on every shift during a three week timeframe. Additionally, there was documentation of the test result confirming a positive result.

**Sources:** Clinical Records, Interviews with IPAC Lead and Staff

## WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.**
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed when an outbreak was declared.

**Sources:** CI 2950-000014-25, interview with IPAC Lead and Staff

## WRITTEN NOTIFICATION: Safe storage of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**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 failed to ensure that the medication cart on Willow unit was locked when it was not in use.

**Sources:** Observation and interview with staff.