Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2019	2019_770178_0026	014109-19, 016459-19	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): December 2, 3, 4, 2019.

Logs #014109-19/CIR #2646-000006-19 and #016459-19/CIR #2646-000007-19 regarding resident falls were inspected.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Physiotherapist, the RAI Coordinator, the Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector also observed the provision of care and services to residents, residents' environment, reviewed residents' health records, and licensee policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

Review of the resident's health record indicated that resident #001 had a history of falls and had sustained injury when falling in the past.

Critical Incident Report (CIR) #2646-000006-19 was reviewed, and indicated that on an identified date, resident #001 was noted to be agitated at the nursing station, so the PSW assisted resident #001 to the toilet. Resident #001 was left unattended in the bathroom for a brief moment while the PSW retrieved an identified item required for the resident. As the PSW left the washroom they heard resident #001 moving around and returned to the washroom to find resident #001 on the floor.

Resident #001's plan of care indicated that the resident required "a circle of friends for all toileting for safety". The Director of Care indicated to Inspector #178 that this means the resident was never to be left unattended while using the toilet.

PSW #102 indicated to Inspector #178 that they left resident #001 alone on the toilet for a few seconds to obtain an item from the resident's dresser which was only a few feet away. In that time the resident got up from the toilet and fell. PSW #102 indicated awareness that the resident was not to be left alone on the toilet.

As such, the licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to resident #001 as specified in the plan, to be implemented voluntarily.

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Issued on this 24th day of December, 2019

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

Original report signed by the inspector.