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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: March 18, 2024
Inspection Number: 2024-1154-0001
Inspection Type: Critical Incident
Licensee: Gem Health Care Group Limited
Long Term Care Home and City: Groves Park Lodge, Renfrew

Lead Inspector	**Inspector Digital Signature**
Dee Colborne (000721)	Diana (Dee) Colborne Digitally signed by Diana (Dee) Colborne Date: 2024.03.19 08:07:12 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 11, 12, 13, 14, 2024

The following intake(s) were inspected:

- Intake: #00093473 - Resident to resident alleged physical abuse.
- Intake: #00103076 - Unwitnessed fall of a resident resulting in significant injury.

Inspector #000858 was present in an observer role during this inspection.

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

Infection Prevention and Control
Safe and Secure Home

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, specifically the clean and soiled utility rooms and janitor rooms.

Rationale and Summary:
During the Inspectors' initial tour of the home on a specified date in March 2024, Inspector observed a utility room, on a specified unit, that was slightly ajar and was easily opened by the Inspector. There was a swipe card access noted outside the door, but it was not engaged. The room had several commode chairs, a wash basin station, a bottle of vinegar that was three quarters full and an enclosed garbage bag that appeared full. Further into the tour of the home, Inspector also noted another

door, which did not have any type of locking mechanism on the door and was easily pushed open by the Inspector. Inside the room it was noted that there was an ARJO disinfectant machine along with bed pans and other supplies. Inspector also observed another utility room door on another specified resident care area to not be locked or secured. This door had a keypad mechanism as well as a swipe card access but neither was engaged and the Inspector was able to easily open the door. Another room on this home area was also easily opened and found to not be locked or the swipe access engaged. Inside the room, it was noted there was an ARJO disinfectant machine. Inspector then proceeded to another specified area in the home and noted the a couple of other utility room doors to be easily opened and not locked or secured.

During an Interview with the maintenance supervisor, on a specified date in March 2024, they confirmed these doors were equipped with locks requiring swipe card access but the locks were never engaged.

During an Interview with the Administrator, on a specified date in March 2024, they confirmed that the utility and storage room doors that are considered non-resident areas have never been locked. They were equipped with swipe access during COVID, but the decision was made to not lock them. They later confirmed that the doors would be locked before end of day.

By not ensuring doors to non-residential areas are closed and locked, places increased risk for residents for entering these rooms and places them at risk of harm.

Sources: Inspector observations, interviews with maintenance supervisor #100, Administrator and other staff.

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

[000721]

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559