

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

Original Public Report

Report Issue Date: September 19, 2024

Inspection Number: 2024-1433-0004

Inspection Type:

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 dates September 9-13, 2024

The following intakes were inspected in this inspection:

- Intake #00118488, related to Infection Prevention and Control
- Intake #00123134, and Intake #00124084, related to falls.

The following intakes were also reviewed during this inspection:

Intake #00116731, Intake #00117090, Intake #00119495, and Intake #00120129 related to falls.

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

- Infection Prevention and Control
- Falls Prevention and Management

INSPECTION RESULTS

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

WRITTEN NOTIFICATION: Required Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The Licensee failed to ensure that the home's falls prevention program was followed, specifically to completed a post-fall assessment note every shift for 48 hours after a fall.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes the monitoring of residents, reduce the risk of injury and that it must be complied with.

Rational and Summary

The home's policy titled "Fall Prevention Program", instructed staff to complete a post-fall assessment note on every shift for 48 hours.

Post-falls assessment notes were not completed for a resident on two shifts following the resident's fall.

By not completing post- falls assessment notes, there was a chance that injuries or

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

a change in resident's condition could have gone undetected and delay necessary interventions and treatment.

Sources: Resident's clinical record; Falls Prevention Program policy # NUR-05-11 revised November 2023; interview with the Director of Care.