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**

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 rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 18, 2020 | 2020_770178_0014 | 004553-20, 010632-20 | Complaint |

### Licensee/Titulaire de permis

Arnprior Regional Health
350 John Street North ARNPRIOR ON K7S 2P6

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

The Grove, Arnprior and District Nursing Home
275 Ida Street North ARNPRIOR ON K7S 3M7

### 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 Complaint inspection.**

**This inspection was conducted on the following date(s): November 6, 10, 12, 13, 2020.**

**The following intakes were completed in this complaint inspection:**
**Log #004553-20/CIS #2699-000003-20 was related to a fall with injury;**
**Log #010632-20 was related to falls and medication administration.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Resident Care Coordinator (RCC), a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a resident, a resident's family.**

**During the course of this inspection, the inspector observed residents, resident home areas and equipment, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

A resident fell out of bed while being changed by two PSWs. The resident had been rolled towards one PSW during care, was positioned too close to the edge of the bed, and the PSW failed to ensure that the resident remained safely in the bed.

The same resident slid out of their chair and onto the floor while a lift sling was being applied under the resident with two PSWs present. The resident's seat belt was removed before the lift sling was fully applied, which allowed the resident to slide out of their chair.

Sources: Interviews with a resident, PSWs, and the Resident Care Coordinator (RCC); a resident's progress notes and Post Fall Huddle notes. [s. 36.]

***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 staff uses safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no drug was administered to a resident unless the drug has been prescribed for the resident.

An RN mistakenly administered medications to a resident that were not prescribed for the resident. The RN did not appropriately verify the resident's identity and mistakenly administered medications that were meant for another resident. The resident was assessed and monitored for harm after the incident and did not suffer adverse effects as a result of the error.

Sources: Interviews with an RN and the RCC; progress notes for a resident, and the Medication Incident Report. [s. 131. (1)]

***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 no drug is administered to a resident unless the drug has been prescribed for the resident, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,**
**(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and**
**(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed within three business days of an incident that caused an injury to a resident for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition.

A resident sustained an injury after sliding out of their wheelchair. The licensee became aware of the injury within two business days of the incident but notified the Director under the Long-Term Care Homes Act eight business days after the incident occurred.

Sources:
CIS #2699-000003-20 and a resident's progress notes; interview with the RCC. [s. 107. (3.1) (b)]

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**Issued on this 19th day of November, 2020**

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

**Original report signed by the inspector.**