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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2022	2022_935483_0004	019514-21, 020304-21, 020429-21	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 Nursing Home
274 Ida Street North Arnprior ON K7S 3M7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KAREN BUNESS (720483), 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): February 9, 10, 11, 14, 15, 16, 2022

The following intakes were completed in this complaint inspection:
Log # 09514-21 was related to a missing resident
Log # 020304-21 was related to recreation activities and infection prevention and control
Log # 020429-21 was related to sufficient staffing

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), a Recreation Aide, a Housekeeper, a Registered Practical Nurse (RPN), Registered Nurses (RNs), the Manager of Building and Environmental Services, the Resident Care Manager and the Administrator.

During the course of the inspection the inspectors observed staff resident interactions, recreation activities, infection prevention and control procedures and reviewed clinical health records, relevant home policy and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Recreation and Social Activities
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and the outside of the home were kept closed and locked.

The stairwells and the main exit of the home were found to be unlocked. It is believed that a very brief power outage that evening caused the magnetic lock system to reset and resulted in the handicap paddle on the main door opening the door when it should have remained locked. Staff working at the time were unaware that the magnetic lock on the main door's handicap paddle was not working as intended. This situation caused risk of harm to a resident who left the home unattended through the main door by pressing the handicap paddle, and was found outside in clothing that was inappropriate for the weather.

Sources: Resident #002's progress notes; interviews with RN #103, the Resident Care Manager and the Manager of Building and Environmental Services. [s. 9. (1) 1. i.]

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 all that all doors leading to stairways and the outside of the home other than doors leading to secure areas that preclude exit by a resident, including balconies and terraces or doors residents do not have access to must be kept closed and locked., to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #002's written plan of care set out the planned care, goals and interventions to reduce their risk of elopement.

The resident was known by staff to be at risk for elopement and was not to exit the unit or building unaccompanied. The resident had a wander guard which would lock the doors if the resident approached the doors exiting their unit or the building. Registered nursing staff and the Resident Care Manager indicated that if a resident is wearing a wander guard to prevent elopement, this should appear on the resident's plan of care. The resident's risk of elopement, goals and interventions to prevent elopement did not appear on the resident's written plan of care. This posed a risk of harm to resident as new staff may not be aware of the resident's care needs with regards to risk of elopement.

Sources:
Interviews with a RN and the Resident Care Manager; Resident's clinical health record.
[s. 6. (1)]

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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director under the Long-Term Care Homes Act (LTCHA) is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

Resident left the building without the staff's knowledge, and was found approximately 100 metres from the home. The weather was cold and the resident was not wearing a jacket or coat. Staff was notified and convinced the resident to return to the home. The resident was not harmed. The Director under the LTCHA was not informed of the incident via the After Hours reporting system or the Critical Incident reporting system. The Resident Care Manager indicated that the home management was unaware that the incident should be reported to the Director.

Sources:
Resident progress notes; interview with a RN and the Resident Care Manager. [s. 107. (3) 1.]

Issued on this 28th day of February, 2022

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

Original report signed by the inspector.