Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Public Report

Report Issue Date: November 18, 2025
Inspection Number: 2025-1198-0004
Inspection Type: Critical Incident
Licensee: Arnprior Regional Health
Long Term Care Home and City: The Grove Nursing Home, Arnprior

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6, 7, 12, 13, 14, 17, 18, 2025

The following intake(s) were inspected:
Intake: #00156017- Incident causing injury to a resident.

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

Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bed Rails

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (b)

Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

A resident sustained an injury in August 2025 from an incident. Steps were not taken to prevent entrapment when bed rails were installed on a resident's bed as confirmed by staff. During an interview with another staff member, they acknowledged the time between when the change with the bed system took place in April 2025 and when the entrapment assessment was conducted in September, 2025.

Sources: Interview with staff members and the Bed and Resident Safety Assessment sheet.

COMPLIANCE ORDER CO #001 Bed rails

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 18 (1) (a)
Bed rails
s. 18 (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and the resident's bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1a)The licensee shall develop and implement a program to ensure that where bed rails are used, the resident's bed system is evaluated in accordance with the prevailing practices outlined in the following document: "Guidance Document – Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008" (the Guidance document). The program must include, but is not limited to:
b) Staff responsible for conducting bed system evaluations must receive training and ongoing support. Their competency must be verified to ensure evaluations are performed in accordance with the Guidance document including correct use of the testing tool and accurate documentation of results.
c) A detailed inventory of all bed systems with rails to be developed and maintained. Records must include evaluation information and results such as identifying information for the bed deck, mattress, rail type, rail positions (e.g. rotating rail in the up and or in the down position), condition of rail with corrective action as required, entrapment zone testing and results. All bed system components must be traceable. Information about mattress compatibility must be clearly and permanently marked on the bed.

2. Document and keep a record of the education provided, including topics covered, the names of the staff in attendance, date, and who provided the education.

3. Written records will be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

There were five resident bed systems that were not evaluated in accordance with evidence based practices or prevailing practices.

During an interview with staff, they confirmed that the entrapment assessments that were conducted on a day in September, 2025, were not completed in accordance with prevailing practices for bed rails. Specifically, they confirmed that no education was provided instructing them on how to conduct the entrapment assessments.
During a record review of the entrapment assessments that were completed on a day in September, 2025, not all applicable zones of entrapment were assessed for two residents.
Also, during an interview with staff, they acknowledged the gap between the time the bedrails were installed and when the entrapment assessments were completed. The gap was several months.
In the licensee's bed rail policy, it states that bed rails should not be implemented until a bed entrapment assessment has been completed.

Sources: Interview with staff, the bed entrapment inspection sheet, the licensee's bed rail policy.

This order must be complied with by January 26, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.