Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 4, 2016	2016_290551_0005	005263-16	Critical Incident System

Licensee/Titulaire de permis

ARNPRIOR (THE) AND DISTRICT MEMORIAL HOSP.
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

MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 2 and 3, 2016.

This inspection related to a Critical Incident Report due to the unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), a Dietary Aide, Registered Nursing Staff and the Assistant Director of Care.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **1 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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 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 the written plan of care for resident #001 set out clear directions to staff and others who provided direct care to the resident.

Resident #001 was admitted to the home in 2014. The most recent written care plan indicated that the resident had a full upper denture and that staff were to ensure that the denture was clean and in place.

Since admission resident #001 was ordered a regular texture diet. PSW #102 stated that the resident fed himself/herself and chose his/her meals. Dietary Aide #101 stated that resident #001 used an adaptive feeding aide and was not flagged as a resident at risk for choking.

On a specified day in February 2016, resident #001's airway became obstructed while eating a sandwich at lunch. Staff attempted the Heimlich maneuver, suctioning, compressions and manual clearing but were not able to clear the airway. Resident #001 was taken to hospital where he/she was pronounced dead.

The home's investigation noted that the resident was not wearing his/her denture when the obstruction occurred. According to the Assistant Director of Care (ADOC), resident #001 had eaten half of the meat from the sandwich and no bread.

The ADOC, RPNs #103 and 104 and PSWs #102, 105 and 106 stated that resident #001 was known to be resistive to wearing his/her denture. Resident #001 was able to take the denture out and did so often.

According to the ADOC, the Point of Care system would generate a task, to be performed with morning care, that would prompt the PSW to insert resident #001's denture and to make sure that it was clean and in place. The ADOC stated that the plan of care should have referenced that the resident was known to be resistive to wearing the denture and that he/she removed it on his/her own.

RPN #107 who regularly reviewed the resident's kardex/plan of care with the MDS assessment stated that the kardex/plan of care should have referenced that resident #001 was known to remove his/her denture and should have directed staff to be encouraging the resident every day to keep the denture inserted.

Resident #001's plan of care did not direct staff to the fact that that he/she was known to be resistive to wearing the denture, that he/she was known to remove it often or that he/she required encouragement to keep it inserted. [s. 6. (1) (c)]

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 the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident as it relates to the resident's dental care needs, to be implemented voluntarily.

Issued on this 4th day of March, 2016

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

Original report signed by the inspector.