

**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) 569-9670Bureau 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**

---

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Nov 18, 2020	2020_770178_0015	006922-20, 009452- 20, 011734-20, 011963-20	Critical Incident System

---

**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 Critical Incident System inspection.**

**This inspection was conducted on the following date(s): November 6, 10, 12, 13, 16, 2020.**

**The following intakes were completed in this Critical Incident System Inspection: Log #006922-20/CIS#2699-000005-20 was related to a fall with injury; Log #009452-20/CIS#2699-000006-20, Log #011734-20/CIS#2699-000007-20, and Log #011963-20/CIS#2699-000008-20 were related to a controlled substance missing/unaccounted for.**

**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), and a resident.**

**During the course of this inspection, the inspector observed residents, resident home areas and equipment, and end of shift narcotic count, 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.**

**1 WN(s)  
0 VPC(s)  
0 CO(s)  
0 DR(s)  
0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

---

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**  
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**  
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the “Narcotic Counts” policy in the Medication Management System was complied with.

O. Reg. 79/10, s. 114(1) requires an interdisciplinary medication management system to provide safe medication management for residents and (2) requires that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing and storage of all drugs used in the home.

The “Narcotic Counts” policy indicated that during shift change narcotic count, the oncoming nurse will verify to ensure that the number of narcotic medication remaining matches the number written on the resident's individual narcotic count sheet. The oncoming nurse will then verbally state the number of each narcotic medication remaining to the outgoing nurse, who will record the number. During end of shift narcotic count, the oncoming nurse is not always verifying to ensure that the number of narcotic medication remaining, matches the number written on the resident's individual narcotic sheet.

**Sources:**

Narcotic Counts Policy; interviews with an RPN, the RCC, the DOC, and other staff; observation of end of shift narcotic count. [s. 8. (1) (b)]

**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.**