Ontario

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

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

Ottawa District
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Original Public Report

Report Issue Date: March 10, 2023

Inspection Number: 2022-1198-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Arnprior Regional Health

Long Term Care Home and City: The Grove Nursing Home, Arnprior

Lead Inspector	**Inspector Digital Signature**
Gurpreet Gill (705004)	Gurpreet K Gill Digitally signed by Gurpreet K Gill Date: 2023.03.15 11:54:09 -04'00'

Additional Inspector(s)
Karen Buness (720483)

INSPECTION SUMMARY

The inspection occurred on the following date(s): December 12, 13, 15, 19-22, 29-30, 2022, January 3, 4, 6, and 10, 2023.

The following intake(s) were inspected:

- Intake: #00002184- complaint related to care and services to residents including dressing, medication administration, skin and wound, nutrition and hydration, laundry and housekeeping services, infection prevention and control, and concerns related to insufficient staffing and family council
- Intake: #00002898- complaint related to care and services to residents and insufficient staffing
- Intake: #00005021- complaint related to insufficient staffing
- Intake: #00007311- [CI: 2699-000004-22] related to medication management
- Intake: #00006588- [CI: 2699-000010-22] related to alleged staff to resident abuse
- Intake: #00002439- [CI: 2699-000007-22] related to a fall incident that caused injury to a resident and a significant change in condition
- Intake: #00005236- [CI: 2699-000011-22] related to a fall incident that caused injury to a resident and a significant change in condition

- Intake: #00013113- [CI: 2699-000019-22] related to a fall incident that caused injury to a resident and a significant change in condition
- The following intakes were completed in the Critical Incident System Inspection: Intake: #00003692, CI: 2699-000014-22; Intake: #00006652, CI: 2699-000005-22; Intake: #00011010, CI: 2699-000017-22 and Intake: #00013293 - 2699-000020-22 were related to fall incidents that caused injury to residents and resulted in a significant change in condition.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of the resident.

Rationale and Summary

The resident's clinical records described that the resident expressed a dislike and refusal of thickened fluids.

During an interview, Registered Dietitian (RD) indicated that the resident did not like thickened fluids.

An interview with an RN indicated that they did not assess the resident before and after when they made the dietary referral to change the fluid consistency to thickened fluids. The RD indicated that the change to the resident's fluids was made on the specified date and discontinued twenty three days later.

As such, failing to assess the resident's needs and preferences before making any changes in the resident's plan of care, may pose a potential risk of harm to the resident's fluid intake.

Sources: The resident's health care record and Interview with an identified staff member. [705004]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that the resident, the resident's substitute decision-maker if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

The resident's Substitute Decision Maker (SDM) indicated that they were unaware that the resident was receiving thickened fluids.

A review of the resident's health care records indicated that a dietary requisition and a dietary referral to change the fluids was made on two specified dates in the same month. But there was no documentation indicating whether the SDM was notified about the change in the fluids.

During an interview, an RN indicated that they did not inform the SDM when they made the dietary requisition and dietary referral to change the resident's fluid consistency.

The Resident Care Manager indicated that the SDM was not notified when the resident's fluids were changed. The Resident Care Manager acknowledged that the SDM is supposed to involve in the decision-making process.

Failing to involve the resident's SDM in the resident's plan of care as required by the legislation led to the SDM unable to advocate for the resident in their preferences.

Sources: The resident's health care record, interviews with the Resident Care Manager, the RN and, the SDM. [705004]

WRITTEN NOTIFICATION: Directives by the Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

As per FLTCA, 2021, s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The home has failed to ensure their Infection Prevention and Control (IPAC) Program includes surveillance protocols issues by the Director, specifically the Public Health Ontario (PHO) COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes.

Per section 1.1 of the Minister's Directive, licensees shall ensure measures are taken to prepare for and respond to a COVID-19 outbreak, including ensuring the development and implementation of a COVID-19 Outbreak Preparedness Plan. This plan must, among other things, include conducting regular IPAC audits in accordance with this guidance document. Licensees must complete IPAC audits every two weeks unless in outbreak. When a home is in outbreak, IPAC audits must be completed weekly. At minimum, homes must include in their audit the PHO's COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes.

Rational and Summary

In December 2022, the IPAC Lead reported as part of their role they are responsible for overseeing the completion of IPAC audits however the Public Health Ontario (PHO) COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes was not one of the audit tools being used by the home.

In December 2022, the Resident Care Manager stated the home was unaware the audit tool had been changed therefore the home has been completing the Public Health Ontario - Supporting the Use of Personal Protective Equipment weekly when the home is on outbreak and biweekly when the home is not on outbreak in error.

A review of the Public Health Ontario- Use of Personal Protective Equipment (PPE) Audit tool revealed the tool does not include all of the areas as the COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes does. The Public Health Ontario PPE Audit tool does not include monitoring the implementation and ongoing adherence to IPAC practices.

Failure to ensure the Infection Prevention and Control program includes audits which prepare the home for COVID-19 outbreaks puts the home at risk for being not able to respond to COVID-19 outbreaks adequately.

Sources: Record reviews, interviews with IPAC Lead and Resident Care Manager [720483]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed within one business day when the resident fell and sustained an injury as a result of a fall, and was taken to the hospital, resulting in a significant change in their health condition.

Rational and Summary

A Critical Incident System (CIS) report was submitted related to an incident that resulted in an injury and a significant change in the residents condition.

The Resident Service Manager indicated that the CIS report for the resident's fall was initiated at the time of the fall however it was deleted as it was not submitted within twelve days.

The Critical Incident Report was submitted to the Director seventeen days after the incident, and sixteen days after the diagnosis of an injury that resulted in a significant change in their health condition.

Sources: Critical Incident System report, the resident's health care record, and interview with the Resident Services Manager. [705004]

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