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

Original Public Report

Report Issue Date: August 14, 2023	
Inspection Number: 2023-1198-0002	
Inspection Type: Critical Incident System	
Licensee: Arnprior Regional Health	
Long Term Care Home and City: The Grove Nursing Home, Arnprior	
Lead Inspector Gurpreet Gill (705004)	**Inspector Digital Signature** Gurpreet K Gill Digitally signed by Gurpreet K Gill Date: 2023.08.29 13:09:59 -04'00'
Additional Inspector(s) Martin Orr (000747) Ashley Martin (000728)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 8-9, 12-14, 2023

The following intake(s) were inspected:

- Intake: #00084810 - CI: 2699-000006-23 - related to medication management
- Intake: #00020802 - CI: 2699-000003-23 - related to alleged resident to resident abuse
- Intake: #00084912 - CI: 2699-000007-23 - related to alleged resident to resident abuse
- Intake: #00087674 - CI: 2699-000008-23 - related to alleged resident to resident abuse
- Intake: #00087916 - CI: 2699-000009-23 - related to a fall incident that caused injury to a resident and a significant change in condition

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The home has failed to document their immediate actions taken to maintain the resident's health following a medication error.

Rationale/Summary Statement

On a specific day in March 2023, a resident received medication by mouth when the resident had an order for under the tongue. After record reviews and an interview with the responding Registered Nurse (RN), the home failed to document their assessment to maintain the resident's health following the identified medication error.

On the same day in March 2023, it was reported by another resident in the evening that the order for a specific medication was administered at 1200 hours instead of 1600 hours as prescribed. The Registered Nurse confirmed that they failed to document their immediate actions taken to maintain the resident's health following the identified medication error.

Failing to document their immediate actions taken to maintain the resident's health following a medication error increases the risk of potential harm to the resident.

Sources: Interview with the RN and the resident's health care record. [000728]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

The home has failed to notify the power of attorney/substitute decision maker and notify the physician following an identified medication error.

Rationale/Summary Statement:

On a specific day in March, a resident received medication by mouth when the order was under the tongue. After record reviews and an interview with the responding Registered Nurse, the home failed to notify the substitute decision maker, and failed to notify the physician following an identified medication error.

On the same day in March 2023, it was reported by another resident in the evening that the order for a specific medication was administered at 1200 hours instead of 1600 hours as prescribed. The Registered Nurse confirmed that they failed to notify the physician following the identified medication error.

Failing to notify the substitute decision maker, and failing to notify the physician following a medication error increases the risk of potential harm to the resident.

Sources: Interview with the RN and the resident's health care record. [000728]

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