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
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Original Public Report

Report Issue Date: March 12, 2024	
Inspection Number: 2024-1198-0001	
Inspection Type: Critical Incident	
Licensee: Arnprior Regional Health	
Long Term Care Home and City: The Grove Nursing Home, Arnprior	
Lead Inspector Gurpreet Gill (705004)	**Inspector Digital Signature**
Additional Inspector(s) Ashley Martin (000728)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6, 7, 8, 9, 13, 14, 2024

The following intake(s) were inspected:

- Intake: #00102073 [CI: 2699-000026-23] related to written complaints to the home regarding issues with care and services provision.
- Intake: #0010257 [CI:2699-000031-23] related to alleged staff to resident abuse
- Intake: #00101254 [CI: 2699-000022-23] related to a fall incident that caused injury to a resident and a significant change in condition
- Intake: #00105753 [CI: 2699-000002-24] related to a fall incident that caused injury to a resident and a significant change in condition

- The following intake was completed in the Critical Incident System Inspection: Intake: #00092025 CI: 2699-000017-23 was related to a fall incident that caused injury to a resident and resulted in a significant change in condition.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy was complied with for a resident.

Rationale and Summary

A Critical Incident System (CIS) report was submitted on a day in November 2023 at 1327 hours to the Director related to an allegation of staff to resident physical abuse that occurred four days prior.

A review of the home's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy indicated that any allegations of abuse of resident must be reported immediately to the reporting manager/delegate.

The Resident Service Manager indicated that the alleged incident of physical abuse was not immediately reported to the Director as a Personal Support Worker (PSW) did not report the incident to the registered staff on the unit. Furthermore, they acknowledged that the alleged incident of physical abuse should be reported immediately to the Director.

As such, not reporting this incident of alleged abuse of the resident, could potentially place the resident at risk of not receiving appropriate follow-up.

Sources: Critical Incident System report, Policy Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, and interview with the Resident Service Manager. [705004]

WRITTEN NOTIFICATION: Orientation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (2) 1.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.

The licensee has failed to ensure that a Personal Support Worker (PSW) received training in the areas of the Resident's Bill of Rights, prior to performing their responsibilities.

Rationale and Summary

A review of the PSW's training records provided by the home revealed that the PSW did not complete the Resident's Bill of Rights as required areas of training prior to performing their responsibilities in the home.

The PSW indicated that they had not completed the training since starting several months earlier.

The Resident Care Manager indicated that the PSW did not complete the required education topics.

Failure to ensure staff receive training, specific to the Resident's Bill of Rights upon hire, places the residents at an increased risk.

Sources: A review of training records (surge learning), and interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Orientation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 3.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

The licensee has failed to ensure that a PSW received training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

Rationale and Summary

A review of the PSW's training records, provided by the home, revealed that the PSW did not complete the Long-Term Care Home's policy to promote zero tolerance of abuse and neglect of residents as required areas of training prior to performing their responsibilities in the home.

The PSW indicated that they had not completed the training since starting several months earlier.

The Resident Care Manager indicated that the PSW did not complete the required education topics.

Failure to ensure staff receive training in abuse prevention upon hire may compromise their ability to follow proper protocol for prevention of abuse and

neglect

Sources: A review of training records (surge learning), and interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Orientation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 4.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
4. The duty under section 28 to make mandatory reports.

The licensee has failed to ensure that a PSW received training on the duty under section 28 to make mandatory reports prior to performing their responsibilities.

Rationale and Summary

A review of the PSW's training records, provided by the home, revealed that the PSW did not complete the duty under section 28 to make mandatory reports as required areas of training prior to performing their responsibilities in the home.

The PSW indicated that they had not completed the training since starting several months earlier.

The Resident Care Manager indicated that the PSW did not complete the required education topics.

Failure to ensure staff receive training in abuse prevention upon hire may compromise their ability to follow to follow the home's reporting protocols.

Sources: A review of training records (surge learning), and interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Orientation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 5.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
5. The protections afforded by section 30.

The licensee has failed to ensure that a PSW received training on the protections afforded by section 30 (Whistle-blowing protection) prior to performing their responsibilities.

Rationale and Summary

A review of the PSW's abuse training records, provided by the home, revealed that the PSW did not complete the protections afforded by section 30 (Whistle-blowing protection) as required areas of training prior to performing their responsibilities in the home.

The PSW indicated that they had not completed the training since starting several months earlier.

The Resident Care Manager indicated that the PSW did not complete the required education topics.

Failure to ensure staff receive training upon hire may compromise their ability to adhere to proper protocols for preventing abuse and neglect.

Sources: A review of training records (surge learning), and interviews with identified staff members. [705004]

WRITTEN NOTIFICATION: Directives by Minister

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
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 Licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when they did not complete weekly IPAC audits while the home was in an outbreak from December 24, 2023 to January 10, 2024.

The Minister's Directive, COVID-19 response measures for long-term care homes directed homes to conduct regular IPAC audits in accordance with the COVID-19 Guidance Document for Long-Term Care Homes in Ontario. The guidance document stated long-term care homes must complete IPAC audits at least quarterly, in alignment with the requirement under the IPAC standard. When a long-term care home is in outbreak, the IPAC audits must be completed weekly. At minimum, the audits must include Public Health Ontario's "COVID-19: Self-

Assessment Audit Tool for Long-Term Care Homes and Retirement Homes".

Rationale and Summary

The IPAC lead confirmed that the home experienced COVID-19 outbreak from December 24, 2023, until January 10, 2024, concurrently with a respiratory outbreak.

A record review of the home's Public Health Ontario's (PHO's) COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes indicated that this was not completed between December 24, 2023 to January 1, 2024,

The IPAC lead confirmed that the audit tool was not completed during the outbreak between December 24, 2023, and December 31, 2023.

Failure to complete weekly IPAC audits during a COVID-19 outbreak, puts the home at risk for being not able to respond to COVID-19 outbreaks adequately and undetected gaps in the home's infection prevention and control measures.

Sources: Home's IPAC self-assessment audit records and interview with the IPAC Lead. [705004]

WRITTEN NOTIFICATION: Required programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following

interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to comply with their written procedure related to fall prevention and management for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee is required to ensure that their written policy related to fall prevention and management is complied with.

Specifically, staff did not comply with the licensee policy titled Falls Prevention and Management Program, RC-15-01-01 last reviewed March 2023.

Rationale and Summary

On a day in January 2024, a resident sustained a fall resulting in a transfer to the hospital on the second day after the fall. A review of the resident's health records and an interview with the Resident Care Manager confirmed that the resident was assisted to ambulate by Personal Support Workers (PSWs) prior to an assessment from a registered staff member.

According to the licensee policy titled Falls Prevention and Management Program last reviewed March 2023, RC-15-01-01, the post fall procedures include that a resident will not be transferred or assisted to ambulate until they are assessed by a registered nurse.

Failure to ensure the resident was assessed prior to ambulation posed a risk of further injury to the resident.

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Sources: Interview with the Resident Care Manager and the resident's health records and the home's Falls Policy dated March 2023. [000728]

WRITTEN NOTIFICATION: Falls prevention and management

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

Non-compliance with: O. Reg. 246/22, s. 54 (2) Falls prevention and management

The licensee has failed to ensure when a resident had a fall, that a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary:

On a day in January 2024, a resident had an unwitnessed fall that resulted in a transfer to the hospital on the second day after the fall. A review of the resident's health care records confirmed that no post fall assessment was found for the resident's fall on a day in January 2024.

During an interview with the Resident Care Manager, they indicated that a post fall assessment was not completed at the time of the fall for the resident and indicated that Registered Nursing staff are required to complete a post fall assessment after each fall.

Failure to ensure a post-fall assessment was completed after the resident sustained a fall on a day in January 2024, posed a risk of not identifying any potential harm and implementation of interventions in a timely and appropriate manner.

Sources: A resident's health care records and interview with the Resident Care Manager. [000728]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

a) The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control, specifically related to additional precautions signage indicating that enhanced IPAC control measures are in place as is required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary

On two consecutive days in February 2024, Inspector observed that a resident in a specified home area had personal protective equipment (PPE) supplies at the room entrance but there was no signage posted at the entrance to the resident's room or bed space indicating that enhanced IPAC measures were in place for this resident. A PSW indicated that the resident was on additional precautions and the signage may

have been misplaced.

On two other consecutive days in February 2024, Inspector observed that another resident in a specified home area had personal protective equipment (PPE) supplies at the room entrance but there was no signage posted at the entrance to the resident's room or bed space indicating that enhanced IPAC measures were in place for this resident.

On a day in February 2024, Inspector observed that the resident who resided in a specified home area had personal protective equipment (PPE) supplies at the room entrance. Inspector observed that two PSWs entered the resident's room without donning personal protective equipment, specifically gowns. It was observed that both PSWs were not wearing appropriate PPE (gowns) when they opened the door to the resident's room, who required contact precautions. A PSW was wearing gloves but no gown when they exited the room.

During an interview with the PSW, they indicated that the resident was on contact precautions and acknowledged that they were not wearing a gown. Furthermore, the PSW indicated that they should wear a gown when they were providing direct care to the resident.

Staff not being aware of additional precautions and the PPE required, as signage was not posted for this resident, increased infection control risks among residents and staff on this unit.

Sources: Observations and interviews with identified staff members. [705004

b) The licensee has failed to implement any standard or protocol issued by the

Director with respect to infection prevention and control (IPAC), specifically related to personal protective equipment (PPE) availability and accessibility to staff, appropriate to their role and level of risk as is required by Additional Requirement 6.1 under the IPAC Standard.

Rationale and Summary

On a day in February 2024, Inspector observed that a resident had personal protective equipment (PPE) supplies at the room entrance and contact precaution signage posted to the entrance to the resident's room, indicating that enhanced IPAC measures were in place for this resident.

On two consecutive days in February 2024, Inspector observed that the resident did not have PPE supplies outside of the resident's rooms.

A review of the resident's clinical records indicated that the resident required contact precautions.

During an interview with an IPAC lead, they indicated that staff had removed the signage and the PPE supplies, and PPE supplies were placed again two days later.

Failing to participate in the implementation of the IPAC standard increases the risk of disease transmission among residents and staff when the resident is required to be in additional precautions.

Sources: Observations, the resident's health care records, and interview with the IPAC lead [705004]

c) The licensee has failed to implement any standard or protocol issued by the

Director with respect to infection prevention and control (IPAC), specifically related to hand hygiene as is required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary

On a day in February 2024, a PSW was observed with their mask improperly applied (the mask was below the nose) in a dining room of a specified home area. After frequently adjusting their mask, the PSW served drinks to residents without performing hand hygiene between adjusting the mask and serving drinks.

The PSW again adjusted their mask and grabbed a jug from the cart and poured water for a resident. PSW did not perform hand hygiene after adjusting their mask and before picking up a jug from the cart.

Two days later, Inspector observed that a staff member pulled their mask under the chin three times while conducting activities with residents. It was observed that after pulling up and down their mask, they did not perform hand hygiene and continued with the activity.

During an interview with the PSW, they indicated that they forgot to sanitize their hands and they are supposed to sanitize their hands.

IPAC lead indicated that staff should not touch their masks; however, if they do touch their masks, they should sanitize their hands afterward.

As such, a lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Observations, and interviews with identified staff members. [705004]

d) The licensee has failed to ensure that Infection Prevention and Control (IPAC) standard issued by the Director was followed by staff related to masking as required by Additional Requirement 6.7 under the IPAC Standard.

Rationale and Summary

On a day in February 2024, upon entering a specified home area, Inspector observed that a staff member was conducting an activity in the dining area (near the Television area). Seven residents were in front of them, and their mask was pulled under their chin.

During the same activity, Inspector observed that the staff member pulled their mask below the chin twice while seven residents were in front of them.

The IPAC lead indicated that they should have their mask on in the resident home area.

As such, failure to don a mask properly in all the resident areas increases the risk of transmission of infection to residents and other staff.

Sources: Observations and Interview with the IPAC lead. [705004]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.
Infection prevention and control program

s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) lead designated under this section works regularly in that position on site at the home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

Rationale and Summary

During separate interviews with the Administrator and the IPAC lead, they acknowledged that the designated IPAC lead worked 22.5 hours per week.

As such not having a designated IPAC lead regularly on site may affect the home's IPAC program. As the designated IPAC lead's primary responsibility is to oversee the infection, prevention and control program and work with the interdisciplinary team to implement, manage and oversee the infection prevention and control program.

Sources: Interviews the Administrator and the IPAC lead. [705004]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (6)
Reports re critical incidents

s. 115 (6) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 246/22, s. 115 (6).

The licensee has failed to ensure the substitute decision maker (SDM) was notified following a fall that a resident sustained on a day in January 2024.

Rationale and Summary:

On a day in January 2024, the resident sustained a fall resulting in a transfer to the hospital two days later. Based on the resident record review and an interview with the Resident Care Manager, the staff failed to notify the substitute decision maker following the fall.

Failing to notify the SDM following a fall, puts the resident at greater risk as the SDM is not aware of the incident and is unable to advocate for the resident.

Sources: Record review for the resident and interview with the Resident Care Manager. [000728]