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: November 7, 2024
Inspection Number: 2024-1198-0004
Inspection Type: Critical Incident
Licensee: Arnprior Regional Health
Long Term Care Home and City: The Grove Nursing Home, Arnprior

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 5, 6, 7, 2024

The following intake(s) were inspected:

- Intake: #00123963 -Resident to resident alleged sexual abuse
- Intake: #00129536 - Resident to resident alleged sexual abuse

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
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).

The licensee has failed to ensure that any standard issued by the Director with respect to infection prevention and control has been complied with. Specifically, they did not comply with the IPAC standard:
9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program.
At minimum, Additional Precautions shall include: e) Point-of-care signage indicating that enhanced IPAC control measures are in place. They were not in place for two resident rooms.

The home placed point of care signage on the two rooms affected on November 5, 2024 prior to the inspector concluding the inspection.

Sources: Inspector observations, interview with IPAC Lead and Administrator.

Date Remedy Implemented: November 5, 2024.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to report an alleged incident of sexual abuse between two residents which occurred on a specified date in October 2024.

Sources: Clinical records of two residents, ADOC investigation notes, interview with and RPN, ADOC and other staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 4.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
4. Protocols for the referral of residents to specialized resources where required.

The licensee has failed to ensure that protocols are in place for referring residents with responsive behaviours to specialized resources. Specifically, they did not refer

two residents to the homes Behavioural Support staff (BSO) staff, or Geriatric Mental health (GMH), after an incident of alleged sexual conduct on two specified dates in October 2024.

Sources: Clinical records of two residents, Interviews with a BSO staff , DOC and other staff.