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: May 9, 2024
Inspection Number: 2024-1464-0002
Inspection Type: Critical Incident Follow up
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Arbour Heights, Kingston

Lead Inspector	Inspector Digital Signature
Erica McFadyen (740804)	Erica V McFadyen Digitally signed by Erica V McFadyen Date: 2024.05.10 15:20:29 -04'00'

Additional Inspector(s)
Kayla Debois (740792)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24-26, 29-30, 2024 and May 1-3, and 6, 2024

The following intake(s) were inspected:

- Intake: #00108104 CIS# 2982-000005-24 / Intake: #00109418 CIS # 2982-000007-24 / Intake: #00109418 CIS# 2982-000007-24- Unwitnessed fall of a resident resulting in injury
- Intake: #00109251 - Follow-up #1 - FLTCA, 2021 - s. 6 (10) (b) regarding the dietary plan of care for a resident
- Intake: #00110787 CIS #2982-000010-24 -complaint regarding palliative care in the long- term care home

- Intake: #00112374 CIS#2982-000014-24 - Unexpected death of a resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1464-0001 related to FLTCA, 2021, s. 6 (10) (b) inspected by Kayla Debois (740792)

The following Inspection Protocols were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 74 (2) (e) (i)
Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and

In accordance with O. Reg 246 / 22 s. 11(1)(b) the licensee is required to ensure their written policy and procedure related to the weight monitoring system to record weight on admission and monthly thereafter is complied with. Specifically,the long-term care home's Weight and Height Monitoring procedure states that "if a weight loss or gain of 2.0kg or greater is identified as compared to the preceding month, the resident will be weighed again to confirm the variance".

Rationale and Summary
The clinical record for a resident indicated a specified weight increase of over 2kg over one month.

In a progress note written on a specified date by the Registered Dietitian (RD) it was noted that the weight for the resident for that month may not be accurate due to an inaccurate wheelchair weight. No reweight or additional assessment was noted in the clinical record for that month.

In an interview with the RD it was stated that no reweight was done for the month in which a weight gain of more than 2kg was noted.

The risk of not reassessing the resident when a weight increase of 2kg or more was noted in one month is that the weight may not have been correct and may not have accurately reflected the resident's health status.

Sources
Interview with the RD, review of the clinical record for the resident

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WRITTEN NOTIFICATION: Integration of assessment, care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that staff and others involved in different aspects of the care of the resident collaborated with each other in the assessment of the resident.

Rationale and Summary

It was noted in the Nurse-Physician Communication Book that there was a note written on a specified date by an RPN which indicated that a resident was declining and consuming 0-25% of each meal. The note from the RPN requested that the physician speak to the family of the resident regarding palliation or comfort measures.

In a review of the Food and Fluid Lookback Reports for the resident from the two week period during during which the RPN wrote in the Nurse-Physician Communication Book about the resident's decline, it was noted that there were ten days where the resident ate 50% or less of all meals. In the two week period prior to this, the resident was noted to have no days where 50% or less was consumed for all meals.

In an interview with the RPN it was stated that the date they wrote in the Nurse-Physician Communication Book they were concerned about decreased food intake and the potential for pain for the resident. The RPN stated that they did not call the physician or make a referral to the registered dietitian on that date. The RPN stated that a call should have been made to the physician and that a dietitian referral should have been sent.

In an interview with the Director of Care (DOC) it was stated that based on the subject matter of the note left for the physician in the Nurse-Physician Communication Book by the RPN regarding the resident that the physician should have been called. Additionally, it was stated by the DOC that the resident had a decrease in food intake starting in the two weeks prior to the RPN identifying their concerns in the Nurse-Physician Communication Book and that a dietitian referral was not sent.

In an interview with the Medical Doctor (MD) it was stated that the purpose of the Nurse-Physician Communication Book is for non-urgent concerns, and that the concerns written in the book by the RPN should have been addressed that day by calling the physician.

The risk of staff and others involved in the care of the resident not collaborating in the assessment of the resident is that the provision of care may have been delayed.

Sources
Review of the clinical record and Food and Fluid Lookback for the resident, interviews with the RPN, the DOC, and MD.
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WRITTEN NOTIFICATION: Involvement of resident, etc

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall 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.

The licensee has failed to ensure that the substitute decision maker's (SDM's) for the resident were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
On a specified date a note was written in the Nurse-Physician Communication Book by an RPN that the resident was declining and may require palliative care. The first documented conversation in the clinical record between the long-term care home and the SDM's for the resident regarding a decline in status or palliative care was noted nine days later.

In an interview with the DOC it was stated that the SDM's were notified of the resident's decline on a specified date and that they should have been notified when

the concern about a decline in status was identified by the RPN. In an interview with the DOC it was stated that the SDM's of the resident were not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The risk of the SDM's for the resident not being given the opportunity to participate in the development and implementation of the plan of care is that the plan may not have honoured the wishes and preferences of the resident.

Sources
Review of the Nurse-Physician Communication Book, review of the clinical record for the resident, interview with the DOC
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