Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 16, 2019	2019_717531_0025	008022-19, 008180-19, 013197-19	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Arbour Heights
564 Tanner Drive KINGSTON ON K7M 0C3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 26, 27, 28, 29 September 3 and 4, 2019.

the following intake logs were inspected concurrently during this inspection.
Log #008180-19 Critical Incident #2982-000010-19 related to transfer and positioning
Log #013197-19 Critical Incident #2982-000015-19 related to medication administration
Log #008022-19 Critical Incident #2982-000009-19 related to alleged physical abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Pharmacist, resident Substitute Decision Makers (SDM), and residents.
During the course of the inspection the inspector conducted a walking tour of the resident home areas, reviewed resident health care records, observed resident care and services, reviewed medication administration policies and procedures, abuse policy and procedures and the fall prevention program.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan with respect to fall prevention .

An inspection was conducted for intake Log 008180-19-19, CIS #2982-000010-19 which indicated that PSW #103 found resident #001 on the floor on their left side in the bathroom.

During separate interviews with Inspector #531 on August 27, 2019 at 1620 hours, PSW #103 told Inspector #531, that they found resident #001 on the floor in their bathroom laying on their left side. The resident's personal posey alarm was not attached at the time of the fall. RPN #104 indicated that prior to the fall they had assisted resident #001 from the washroom to their lounge chair, the RPN indicated that they did not recall if the resident had the personal posey alarm attached.
Inspector #531 reviewed resident #001's plan of care.
The resident's fall interventions included that a personal posey alarm be applied when the resident was in bed or seated in their chair.

The licensee failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that care is provided to residents as specified in the plan of care related to fall prevention, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse had occurred or may occur, immediately report the suspicion and information which it is based to the Director.

An inspection was conducted in relation to Intake Log #008022-19, Critical Incident System report (CIS) #2982-000009-19 which indicated that on a specified date, PSW #103 reported improper treatment of resident #003, 004, 005 and 007 by PSW #102.

The critical incident documented that on a specified date PSW #103 reported the incident to RPN #104 who reported the incident to RN #106 and RN #107. The CIS report further identified an incident on the same morning whereby RN #106 observed PSW #102 provide care to resident #001, post fall and the resident stated “that is rough.”

During an interview with Inspector #531 on August 27, 2019 at 1630 hours, PSW #103 indicated that on the specified date, the PSW was assisting PSW #102, with morning care for resident #003, 004, 005, 006 and 007. PSW #103 told the inspector that PSW #102, was rushing, moving quickly, pulling, tugging while applying the transfer sling, and transferring of residents. The PSW further indicated that resident #003 and resident #006 vocalized ‘you don’t have to be rough” whereby resident #004, 005 and 007 did not vocalize concern or discomfort.

On August 27, 2019, during separate interviews with RPN #104, RN #106, and #107, they told inspector #531 that prior to being notified of the above incident, while assisting PSW #102, provide continence care to resident #001, post fall, the resident stated “that is rough”. RN #106 further advised that RPN #104 immediately assessed the residents as reported by PSW #103, there were no untoward effects to the residents. RN #106 and 107, removed PSW #102 from duty, initiated an immediate investigation, and notified management. RN #106 indicated that the Director was not notified until April 15, 2019.

During an interview with DOC #101 and review of the critical incident report including investigative documentation, they indicated that the Director was not immediately notified. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 16th day of September, 2019

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.