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 Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 8, 2022
Inspection Number 2022_1464_0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
AXR Operating (National) LP, by its general partners

Long-Term Care Home and City
Arbour Heights, Kingston, ON

Lead Inspector
Darlene Murphy (103)

Additional Inspector(s)
Carrie Deline (740788)

Inspector Digital Signature
Darlene Murphy
Digitally signed by Darlene Murphy
Date: 2022.08.08 11:44:41 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 27-29, August 2, 2022.

The following intake(s) were inspected:

- Log #010704-22 (CIS #2982-000016-22), Log #012240-22 (CIS #2982-000018-22), Log #012634-22 (CIS #2982-000020-22) and Log #012905-22 (Complaint)-resident falls that resulted in injuries, and
- Log #012955-22 (Complaint)-related to resident care.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION FALL PREVENTION AND MANAGEMENT

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure a post-fall assessment was conducted on a resident using a clinically appropriate assessment instrument designed for falls.

Rationale and Summary

An RPN was notified by the PSW to assess a resident who had fallen. Treatment was administered to the resident at that time. Additional injuries were found several hours later when the resident was transferred back to bed by the next shift. The resident was then transferred to hospital for additional assessment and treatment. The ADOC stated the RPN failed to include all aspects of a post-fall assessment to thoroughly assess for injuries.

Failure to ensure a post-fall assessment is conducted using a clinically appropriate assessment instrument designed for falls places residents at risk of receiving delayed treatment.

Sources: interviews with RPN, PSW, ADOC and the resident's progress notes.

(103)