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

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Original Public Report

Report Issue Date: February 24, 2023	
Inspection Number: 2023-1464-0004	
Inspection Type: Critical Incident System	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: Arbour Heights, Kingston	
Lead Inspector Stephanie Fitzgerald (741726)	**Inspector Digital Signature** Stephanie A Fitzgerald Digitally signed by Stephanie A Fitzgerald Date: 2023.02.24 12:45:57 -05'00'
Additional Inspector(s) Kayla Debois (740792)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 6-9, 2023
The following intake(s) were inspected:

- Intake: #00012285 - CIS #2982-000035-22 regarding alleged resident to resident abuse.
- Intake: #00015668 - CIS #2982-000042-22 regarding a resident fall, with sustained injury.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 9.1 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the Licensee shall ensure that there is point-of-care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary:

On a day in February, Inspector observed contact precautions signage outside of a resident's room. The resident's current care plan in PointClickCare stated they required contact precautions, as indicated by the sign on the door. The next day, staff stated the resident was no longer on additional precautions and removed the signage on the door. On that day, the IPAC Lead stated that the resident was still on contact precautions and the signage should still be up.

On a day in February, Inspector observed no additional precautions signage outside of a resident's room that had a Personal Protective Equipment (PPE) cart directly outside the door. The resident's progress notes for this date, in PointClickCare, stated that the resident remained on precautionary isolation. The next day, Inspector observed contact precautions signage outside of the resident's room. While interviewing the IPAC Lead on that day, they were unsure why signage was not up the day prior, confirming it should have been in place.

Failing to ensure appropriate signage is used for residents on additional precautions increases the risk of transmission of infectious agents and can result in illness to the residents.

Sources: Interview with staff #114 and IPAC Lead #104, resident's care plan and progress notes in PointClickCare.

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WRITTEN NOTIFICATION: Required Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that their written policy related to falls prevention and management was complied with. In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their written policy related to falls prevention and management is complied with. Specifically, staff did not comply with the licensee's Falls Prevention and Management and Injury Reduction Procedure

#CARE5-010.05; box four, initiating head injury routine (HIR) and neurovitals for 72 hours.

Rationale & Summary
On a day in December, a resident had fallen, hitting their head. Immediate assessment revealed injury. Two days after the incident, the resident was later transferred to hospital, suffering a fracture.

A review of the resident's clinical record showed a Neurological Flowsheet. The Neurological Flow sheet did not include a Glasgow Coma Scale for three of the required times.

A review of the Post-Falls Management Procedure states that a neurological assessment must be completed for the duration of 72 hours post fall. A review of the accompanying Post Fall Clinical Pathway indicates if a resident hits their head, or a fall is unwitnessed, HIR and neurovitals must be completed for 72 hours. Interviews with staff, and a member of management, confirmed that the Neurological Flowsheet should have been completed for the resident in full, and was not.

By not ensuring the written policy related to falls prevention and management was complied with, the resident was at an increased risk of injury.

Sources: Resident's electronic and hard copy health record; Falls Prevention and Management and Injury Reduction Procedure #CARE5-010.05, revised March 2022; Post Fall Clinical Pathway CARE5-010.05 T1; Interviews with ADOC #103, Staff #117.

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WRITTEN NOTIFICATION: Plan Of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident had a written plan of care that set out clear directions to staff and others who provide direct care to the resident.

Rationale & Summary
On a day in December, a resident had fallen, hitting their head. Immediate assessment revealed injury. Two days after the incident, the resident was later transferred to hospital, suffering a fracture.

A review of the care plan in place at the time of the incident, indicated a specific falls intervention was to be used. However, this intervention was noted to be removed from the care plan, by a member of management several days before the fall occurred. A review of the care plan in place at the time of

inspection, did not include this falls intervention, within the list of current interventions in use.

Observations completed of the resident revealed the falls intervention, was being utilized, at the time of inspection.

Interviews completed with staff members, and a member of management, revealed that the resident has common interventions and strategies in use, that are not captured within the plan of care. Staff advised that interventions for this resident change frequently, and are communicated by word of mouth, or a list provided by management which is made available at the nursing station for for a period of approximately one week. Interviews completed with multiple staff, and a member of management also revealed differing information, on if the use of the specific fall's intervention, is included within the resident plan of care. The resident's plan of care was reviewed during interviews with staff, and all staff agreed the use of the specific fall's intervention is no longer apart of the plan of care, however confirmed they continue to be used daily. Interviews with family confirmed that the falls intervention should not be included in the plan of care at this time.

By not ensuring the written plan of care sets out clear directions to staff and others who provide direct care to the resident, there is a risk that the plan of care will not be complied with. This could place the comfort and safety of the resident at risk.

Sources: Plan of care for at time of incident; Current Plan of Care, Observations of the resident, Interviews with ADOC #103 and other staff.

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