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
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: April 28, 2023	
Inspection Number: 2023-1464-0005	
Inspection Type: Complaint Critical Incident System	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: Arbour Heights, Kingston	
Lead Inspector Wendy Brown (602)	**Inspector Digital Signature** Wendy K Brown Digitally signed by Wendy K Brown Date: 2023.05.09 10:49:30 -04'00'
Additional Inspector(s) Anna Earle (740789)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 18 - 21, 2023

The following intake(s) were inspected:

- Intake: #00008285/CIS #2982-000031-22 regarding improper care and treatment.
- Intake: #00015203/CIS #2982-000040-22 - regarding a fall with injury and transfer to hospital.
- Intake: #00015552/CIS #2982-000041-22 - regarding alleged staff to resident abuse.
- Intake: #00019124/CIS #2982-000005-23 - regarding a fall with injury and transfer to hospital.
- Intake: #00020704/CIS #2982-000008-23 - regarding alleged resident to resident sexual abuse.
- Intake: #00021731/CIS #2982-000010-23 - regarding alleged resident to resident sexual abuse.
- Intake: #00022047 - anonymous complaint regarding resident care and medication administration.
- Intake: #00084277/CIS #2982-000012-23 - regarding medication administration.

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

Medication Management

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Care and Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (2) (a)
The licensee failed to ensure that their infection prevention and control program for the home included evidence-based policies and procedures.

Rationale and Summary
A resident did not receive their prescribed PRN (when needed) nebulized medication as licensee procedures specified that Aerosol Generating Medical Procedures (AGMP) are not to be completed in the home as part of pandemic precautions. Public Health Ontario (PHO) Guidelines in place at the time of the incident outlined that aerosols could be administered with the use of appropriate personal protective equipment in a single room with the door closed.

The Regional Manager and the interim Director of Care (DOC) indicated in interviews that a review of the incident had been completed and the licensee's Infection Prevention and Control (IPAC) policy specific to AGMPs has been revised to reflect current guidelines/ procedures.

Failure to keep IPAC policies and procedures current places residents at risk for not receiving needed treatments. This can impact the overall health, well-being, and quality of life for residents in the home.

Sources: IPAC Standard for Long-Term Care Homes (April, 2022), PHO IPAC Recommendations for Use of PPE for Care of Individuals with Suspect or Confirmed COVID-19, 2nd ed (October 2022), Critical Incident System (CIS) report, resident progress notes, electronic Medication Administration Record(eMAR)s and interviews with the DOC, Regional Manager and other staff. [602]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident, by anyone, that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary
The Director was alerted to an alleged incident of resident-to-resident sexual abuse five days after an incident occurred. In an interview, the DOC acknowledged that the above incident was not immediately reported to the Director.

A delay in reporting critical incidents immediately to the Director, can increase the risk of harm/injury to the resident(s).

Sources
Review of the CIS report and interview with the DOC. [740789]

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use, specified by the prescriber.

Rationale and Summary

A Registered Nurse did not administer a resident their prescribed PRN nebulized medication during an episode of respiratory distress citing licensee procedures that nebulizers were not to be used in the home. In interviews, the Regional Manager and the DOC acknowledged there was an order for PRN nebulizer treatment and the medication could have been administered.

Another resident was prescribed a PRN medication for loose bowel movements. The resident was experiencing increased episodes of loose bowel movements and was not given the prescribed medication for nine days. During an interview with the DOC, it was confirmed that the resident did not receive PRN medication as prescribed.

Failure to administer medication in accordance with the directions for use as specified by the prescriber

delayed treatment for residents. This placed the residents at risk for further decline and other adverse effects.

Sources
CIS reports, resident progress notes and eMARs, MD orders and interviews with the DOC, RN and other staff. [602] [740789]

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