

Original Public Report

Report Issue Date June 9, 2022
Inspection Number 2022_1464_0001
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

Lead Inspector
Wendy Brown (602)

Inspector Digital Signature

Additional Inspector(s)
Erica McFadyen (740804)
Anna Earle (740788)

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 31, June 1-3, June 7-10, 2022

The following intake(s) were inspected:

- Log #004897-22 - Complaint - regarding infection prevention and control practices
- Log #010297-22 - CIS #2982-000014-22 – regarding fall with injury and transfer to hospital
- Log #009203-22 - CIS #2982-000010-22 – regarding fall with injury and transfer to hospital
- Log #009110-22 - CIS #2982-000009-22 – regarding improper continence care/ bowel management resulting in transfer to hospital

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

- Falls Prevention and Management
- Continence Care
- Infection Prevention and Control (IPAC)
- Medication Management
- Resident Care and Support Services
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION - REQUIRED PROGRAMS

NC#1 Written Notification pursuant to O. Reg 246/22 s. 56 (2) (b)

The licensee failed to comply with their bowel management protocol.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to ensure that each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment, and that the plan is implemented.

Specifically, staff did not comply with the resident's constipation protocol outlined in the licensee's Individual Admission Order Set.

A resident was listed as not having had a bowel movement (BM) for 3 days; they did not receive a laxative as prescribed. On day 4, without a BM, the resident did not receive a suppository or a laxative. On day 5 without a BM the resident did not receive an enema, nor was the physician called as outlined in the constipation protocol.

In an interview, the Director of Care (DOC) and the Assistant DOC acknowledged that the bowel protocol was not consistently implemented. There is a risk of intestinal obstruction if a resident does not have a BM for a prolonged period of time.

SOURCES: Critical Incident System (CIS) report, resident's plan of care and electronic Medication Administration Record (eMAR) and interviews with the DOC, ADOC and other staff.

WRITTEN NOTIFICATION - OBTAINING AND KEEPING DRUGS

NC#2 Written Notification pursuant to 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.

A resident should have received a laxative as they were on their third day without a BM. On the following day the resident should have been administered a suppository and a laxative as they had not had a BM. On the resident's fifth day without a BM, the resident did not receive an enema as per physician order.

Another resident was listed as not having had a BM for 3 days; they did not receive the ordered laxative. On day 4, without a BM, the resident did not receive the ordered suppository or laxative. On day 5, the resident did not receive an enema as ordered. On the residents seventh day without a BM the resident was given a suppository without a corresponding order.

In an interview, the DOC and the ADOC acknowledged that omitting the administration of the above medications as outlined in the bowel protocol, as well as the administration of a suppository on day 7 without a BM, would be considered medication errors.

SOURCES: CIS report, resident plans of care, resident eMARs and interviews with the DOC, ADOC and other staff.