



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

#### **Original Public Report**

Report Issue Date Inspection Number	August 8, 2022 2022_1464_0002	
Inspection Type  ⊠ Critical Incident Syst	em   ⊠ Complaint      □ F	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		
<b>Lead Inspector</b> Darlene Murphy (103)		Inspector Digital Signature
Additional Inspector(s Carrie Deline (740788)	s)	

# **INSPECTION SUMMARY**

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

The following intake(s) were inspected:

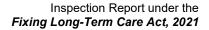
- Log #010704-22 (CIS #2982-000016-22), Log #012240-22 (CIS #2982-000018-22), Log #012634-22 (CIS #2982-000020-22) and Log #012905-22 (Complaint)-resident falls that resulted in injuries, and
- Log #012955-22 (Complaint)-related to resident care.

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)