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: December 9, 2022

Inspection Number: 2022-1464-0003

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	**Inspector Digital Signature**
Carrie Deline (740788)	Carrie E Deline Digitally signed by Carrie E Deline Date: 2023.01.03 11:02:16 -05'00'

Additional Inspector(s)
Polly Gray-Pattemore (740790)
Wendy Brown (602)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 17 and November 22-25, 2022

The following intake(s) were inspected:

- Intake: #00001874 - CI: 2982-000029-22 Regarding a fall with injury of a resident.
- Intake: #00006400 - CI: 2982-000026-22 Regarding improper/incompetent treatment of resident.
- Intake: #00006457 - CI: 2982-000027-22 Regarding improper treatment of resident by a staff member.
- Intake: #00006683 - Regarding a complaint around falls prevention.
- Intake: #00008171 - 2982-000032-22 Regarding resident-to-resident abuse.
- Intake: #00008230 - 2982-000030-22 Regarding staff to resident abuse.
- Intake: #00008971 - Regarding a complaint concerning resident to resident abuse.
- Intake: #00012726 - 2982-000036-22 Regarding a resident fall with injury.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure their zero tolerance of abuse and neglect policy was complied with.

Rationale and Summary

A critical incident was received by the Director from the licensee which indicated that a staff member was witnessed speaking to a resident in an inappropriate tone of voice. The staff member that witnessed the incident reported the incident to a Registered Practical Nurse (RPN) immediately following the incident. The RPN failed to immediately report the information to the most senior supervisor on shift as per the licensee's Resident Non-Abuse Policy.

Failure to immediately report resident abuse or neglect puts residents at risk of additional harm.

Sources: Critical Incident System (CIS) report # 2982-000030-22, investigation documentation, resident's progress notes, interviews with the Director of Care and other staff.
[602]

A critical incident was received by the Director from the licensee which indicated that during a resident transfer to the washroom a staff member grabbed their left upper arm causing a skin tear with hematoma. The licensee's investigation file was reviewed, and the licensee concluded that allegations and evidence had been obtained substantiating abuse. During an interview with Inspector, the DOC indicated that following the incident the resident was distressed and repeated the details of the abuse

frequently to multiple staff members over the course of at least two weeks. Staff failed to protect the rights of the resident entrusted to their care as per the licensee's Resident Non-Abuse Policy.

Failure to protect the rights of residents from abuse or neglect puts residents at risk of additional harm.

Sources: The LTCH's investigative notes; CI: 2982-000027-22; Resident Non-Abuse Policy; resident's health record; and interviews with ADOC, and frontline staff.
(740790)

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

This licensee has failed to ensure that a staff member used safe techniques when repositioning resident #002 in bed.

Rationale & Summary

An incident was reported where staff repositioned a resident in the bed by themselves. During an interview with Inspector #740790, the ADOC confirmed that the staff had repositioned the resident by themselves, and when doing so resident fell out of the bed. The resident was taken to the hospital and diagnosed with a fracture. The resident's plan of care at the time of the incident indicated that they require repositioning with assistance of two staff. Failure to follow a resident's plan of care places a resident at risk for not being provided the care required.

Sources: The LTCH's investigative notes; CI: 2982-000026-22; resident's health record; and interviews with resident, ADOC, PT, RPN and PSW.
(740790)