Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 25, 2019	2019_556168_0015	009814-19, 011635-19, 011636-19, 011637-19, 011638-19, 011639-19	Follow up

Licensee/Titulaire de permis

Rykka Care Centres GP Inc.
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

Long-Term Care Home/Foyer de soins de longue durée

Arbour Creek Long-Term Care Centre
2717 King Street East HAMILTON ON L8G 1J3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LISA VINK (168), DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 12, 13, 16, 17, 18, 19, 20 and 23, 2019.

This inspection was conducted concurrently with Complaint Inspection, inspection number 2019_556168_0016.

This inspection was conducted related to the following intakes:
Log number 009814-19 - for Compliance Order (CO) #001, from Inspection Report 2019_556168_0010 related to the Long-Term Care Homes Act (LTCHA) section (s.) 3(1), regarding the Residents' Bill of Rights;
Log number 011635-19 - for CO #008, from Inspection Report 2019_788721_0016 related to Ontario Regulation (O. Reg.) 79/10 s. 8(1), regarding policies, etc. to be followed;
Log number 011636-19 - for CO #009, from Inspection Report 2019_788721_0016 related to O. Reg. 79/10 s. 9(1), regarding doors in a home;
Log number 011637-19 - for CO #005, from Inspection Report 2019_788721_0016 related to LTCHA s. 20(1), regarding policy to promote zero tolerance;
Log number 011638-19 - for CO #006, from Inspection Report 2019_788721_0016 related to LTCHA s. 24(1), regarding reporting certain matters to the Director; and
Log number 011639-19 - for CO #007, from Inspection Report 2019_788721_0016 related to LTCHA s. 31, regarding restraining by physical device.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), registered nursing staff, personal support workers, housekeeping staff, staff from the Consent and Capacity Board, the physician, the Resident Assessment Instrument (RAI) Coordinator, the Quality Manager, family members and residents.

During the course of the inspection, the inspectors observed the provision of care and services, reviewed relevant policies and procedures, reviewed training records, training material and clinical health records.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #005	2019_788721_0016	581
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #006	2019_788721_0016	581
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2019_556168_0010	168
LTCHA, 2007 S.O. 2007, c.8 s. 31.	CO #007	2019_788721_0016	581
O.Reg 79/10 s. 8. (1)	CO #008	2019_788721_0016	168
O.Reg 79/10 s. 9. (1)	CO #009	2019_788721_0016	168

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments and reassessments were documented.

A. Interview with resident #009 and RPN #111 identified the resident experienced pain in a number of locations related to a diagnosis.
A review of the clinical record identified the presence of pain and that the resident was prescribed as needed and routine narcotic analgesics as well as other non-pharmacologic interventions.
A review of the progress notes and electronic Medication Administration Records (eMAR) identified that the resident was administered as needed analgesics on 17 occasions over a 15 day time period in September 2019; however, the clinical record did not include the location of pain when the resident reported pain.
Interview with the DOC, following a review of the clinical record, confirmed that the assessments of the resident, specifically related to the location of pain were not documented.

B. Resident #008 had a history of pain according to the clinical records.
The progress notes identified that the resident requested and received as needed analgesics on two dates in September 2019.
A review of the clinical records, specifically the progress notes, did not include the location of the pain, an assessment related to why the analgesics were administered.
A review of the clinical record, by the DOC, confirmed that the assessments related to the location of the resident's pain were not documented as required.

C. Resident #011 had a history of pain according to the clinical records and resident interview.
The progress notes identified that the resident requested and received as needed analgesics on three dates in September 2019.
A review of the clinical records, specifically the progress notes, did not include the location of the pain, an assessment related to why the as needed analgesics were administered.
A review of the clinical record, by the DOC, confirmed that the assessments related to the location of the resident's pain was not documented as required.

Actions taken with respect to a resident under a program, specifically assessments and reassessments were not documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments and reassessments are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

The licensee failed to comply with the following requirement of the LTCHA, it was a condition of every licence that the licensee shall comply with every order made under this Act.

1. On May 13, 2019, the following compliance order (CO) #001, from inspection number 2019_556168_0010, made under LTCHA s. 3(1)11iii was issued:
The licensee must be compliant with s.3(1)11iii of the LTCHA, 2007.
Specifically, the licensee must:
1. Inform resident #001 and any other resident of their right to contest a specific decision of capacity and assist the resident(s) to obtain an independent capacity assessment through the appeal process with the Consent and Capacity Board, if they wish to proceed with an appeal.
2. Educate all registered nursing and management staff regarding the Residents' Bill of Rights and consent and capacity.
3. Maintain a record of training completed, participants and date(s) completed.
4. Provide written documentation to the Inspector, on resident #001, following notification

of their rights regarding action(s) taken, when, and the outcome.
The compliance date was July 31, 2019.

The licensee completed step #2, #3 and #4 in CO #001.
The licensee failed to fully complete step #1 in CO #001.
Inform resident #001 and any other resident of their right to contest a specific decision of capacity and assist the resident(s) to obtain an independent capacity assessment through the appeal process with the Consent and Capacity Board, if they wish to proceed with an appeal.

According to the clinical record of resident #001 and meeting minutes, a meeting was held with the resident on an identified date in June 2019, where they were informed, by the physician, of an assessment completed by the physician, regarding a specific decision of capacity. The resident did not agree with the assessment of the physician and as a result the plan was to initiate an appeal with the Consent and Capacity Board (CCB).
A review of the documents provided by the home identified that an appeal was not initiated.
Interview with the ED identified that following the meeting, they, along with the physician and DOC reviewed the CCB Form A - Application of the Board. Their understanding of the Form A was that specified findings could be appealed, under Section 2- Application Type, for three reasons, and it was the opinion, at the time, that the resident did not require an appeal due to their specific situation.
Discussions with the ED, DOC, RPN #111 and the physician identified the resident's abilities.
The ED identified that on an identified date in August 2019, they contacted the CCB, with the DOC, to inquiry about the opportunity to submit an appeal based on the assessment of the physician related to the specific situation that was communicated to the resident in June 2019.
Following this discussion, with the CCB, a Form A application to review the finding was completed and submitted on behalf of the resident.

The licensee failed to comply with the requirements of the LTCHA, the condition of every licence that they complied with every order made under this Act, prior to their compliance due date of July 31, 2019.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that they comply with the following requirement of the LTCHA, a condition of every licence that the licensee shall comply with every order made under this Act, to be implemented voluntarily.

Issued on this 26th day of September, 2019

[redacted]

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.