Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 15, 2020	2020_556168_0011	024318-19	Critical Incident System

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 5, 6, 11, 12, 13, 2020, May 11 and 26, 2020 and September 14, 2020.

This inspection was conducted related to log #024318-19, for Critical Incident System (CIS) number 2930-000019-19, related to prevention of abuse and neglect.

This inspection was conducted concurrently with complaint inspection, report number 2020_556168_0010.

This inspection was conducted by onsite and off site activities.

During the course of the inspection, the inspector(s) spoke with the Administrator, registered practical nurses (RPN), personal support workers (PSW), police, a family member and residents.

During the course of the inspection, the inspector observed the provision of care, reviewed records including but not limited to: investigative notes, clinical health records, training records, human resource files and policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of resident #010 and the preference for specific caregivers.

Interviews with PSWs #104 and #108 identified their knowledge that resident #010 did not always like specific individuals as care givers, which was also communicated by the resident's Substitute Decision Maker (SDM) to the Inspector.
A review of the resident's current plan of care did not include direction related to the resident's preference related to caregivers.
The plan of care noted the resident's care requirements for the level of assistance of care to be provided.
Discussion with the Administrator, identified that they were not previously aware of the resident's preference related to caregivers and the plan of care was subsequently revised based on the preference of the resident.

The care set out in the plan of care was not based on an assessment of the resident and their preferences. [s. 6. (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 the care set out in the plan of care is based on an assessment of the resident and the preferences of the resident, to be implemented voluntarily.

WN #2: 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 resident #010 under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

i. Resident #010 reported an allegation of an incident.
During an investigation, by the management of the home, PSWs #104 and #108, who worked on the shift prior, reported that the resident demonstrated a responsive behaviour, on their shift for which they had to intervene, which was confirmed during PSW interviews with the Inspector.
The resident's plan of care included a focus statement related to the behaviour which was created prior to the allegation and was revised following.
A review of the clinical record, including the progress notes and Point of Care (POC) records for the shift did not include documentation of the behaviour, the interventions of staff or the resident's response, which was confirmed by the Administrator.

ii. Resident #010 reported an alleged incident.
According to the progress notes and staff interviews the resident displayed responses to the allegation.
Interview with the Administrator identified that staff were instructed to and monitored the resident following the allegation for ongoing assessment.
A review of the progress notes did not include the reassessments of the resident, interventions nor the resident's response.
There were no progress notes documented for a period of time greater than 72 hours, as confirmed by the Administrator following a review of the clinical record.

Any actions taken with respect to resident #010 under a program, including reassessments, interventions and the resident’s responses to interventions 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 reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, resident #010, when they exhibited an area of altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #010 was assessed by RPN #102, following an alleged incident at which time a skin alteration was noted, as documented in the progress notes.
The incident report, prepared by RPN #102, noted both that there were no injuries at the time and a new area of skin alteration was noted.
A review of the clinical record, including the assessment tab and skin and wound tab in Point Click Care (PCC), did not include an assessment of the area.
Interview with RPN #102 confirmed that when they assessed the resident they had a mark on their skin. They confirmed that they did not complete a skin assessment tool nor photograph the area/injury.
Interview with the Administrator confirmed an area and that it was not assessed utilizing a clinically appropriate assessment instrument.

The resident, with altered skin integrity did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

Issued on this 16th day of September, 2020

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

Original report signed by the inspector.