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 21, 2021	2021_868561_0008	019786-20, 024232-20, 024674-20, 008825-21, 013138-21, 013306-21	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

DARIA TRZOS (561), LEAH CURLE (585)

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): August 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, 31, 2021 and September 1, 2 (off-site), 3, 2021.

The following Critical Incident System (CIS) reports were reviewed and inspected:
log #019786-20, CIS #2930-000010-20 - related to alleged staff towards resident abuse,
log #024232-20, CIS #2930-000012-20 - related to responsive behaviours,
log #024674-20, CIS #2930-000013-20 - related to responsive behaviours,
log #008825-21, CIS #2930-000010-21 - related to responsive behaviours,
log #013138-21, CIS #2930-000013-21 - related to falls,
log #013306-21, CIS #2930-000014-21 - related to falls.

A complaint inspection number 2021_868561_0007 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Clinical Director of Care/Infection Prevention and Control lead, Staff Development/Quality Improvement staff, Physiotherapist, Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspector(s) observed provision of care, reviewed clinical records, investigation notes, policies and procedures relevant to the inspection and program evaluations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A) An incident had occurred in the home between two residents that caused an injury to one of those residents. The resident that caused the injury to the other resident had a history of responsive behaviours towards other residents. An intervention was implemented to minimize the behaviour; however, the care plan and kardex did not contain the intervention. A PSW that provided direct care to the resident confirmed that the intervention was in place.
The DOC confirmed the resident's responsive behaviour toward co-residents, and that the intervention had not been included in the written plan of care for the resident.

Sources: resident’s progress notes and written plan of care; interview with staff.

B) During this inspection a resident was observed sitting in the lounge area and had a device applied. A registered staff indicated that the device was used as an intervention for falls. The written plan of care and kardex did not have the intervention included. The Staff Development/Quality Improvement staff member who was also the lead for the falls prevention program confirmed that the interventions for falls needed to be documented in the care plan and kardex so that staff were aware of the planned care for residents.

Sources: CIS report; resident’s written plan of care and kardex; progress notes; Falls Prevention Program (reviewed May 2021); interviews with staff. [s. 6. (1) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A resident had a history of responsive behaviours. Their care plan had an intervention in place to deal with the identified behaviour. There was an incident between this resident and a co-resident. A registered staff was interviewed and indicated that the resident’s plan of care was not followed in this situation.
Failure to follow the plan of care resulted in risk of harm to the resident.

Sources: residents’ care plans and progress notes progress notes; interview with staff. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1.The licensee shall protect residents from abuse by anyone.

Ontario Regulation 79/10, section 2 (1) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

A) An incident occurred between two residents that caused an injury to one of the residents. Registered staff was interviewed and confirmed that incident occurred and caused an injury to one of the residents. The resident was not protected from abuse by another resident in the home.

Sources: clinical health records including plans of care and progress notes for residents; interviews with staff.

B) An incident occurred between a PSW and a resident that caused pain to the resident. The resident was interviewed and was able to recall the actions of the PSW. The Executive Director (ED) confirmed that they were able to substantiate abuse towards this resident by PSW staff.
The resident was not protected from abuse by a PSW which caused pain to the resident.

Sources: home’s investigation notes; CIS report; interviews with the resident and staff. [s. 19. (1)]

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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan was developed for each resident and included, at a minimum, with respect to the resident: 1. Any risks the resident may pose to himself or herself, and interventions to mitigate those risks and 2. Any risks the resident may pose to others, and safety measures to mitigate those risks.

A resident was admitted to home in 2020, and the assessment documentation available to the home on admission noted they had a history of identified behaviours. During the 24-hour admission period, the resident exhibited some of those behaviours. Their 24-hour admission care plan did not include any risk the resident may pose to themselves or others, and interventions and safety measures to mitigate those risks, which was confirmed by the DOC.

Sources: resident's admission care plan; progress notes; interRAI Home Care Assessment Form; interview with the DOC. [s. 24. (2)]

Issued on this 22nd day of September, 2021

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

Original report signed by the inspector.