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

Hamilton Service Area Office
119 King Street West, 11th Floor
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Original Public Report

Report Issue Date June 30, 2022
Inspection Number 2022_1414_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Rykka Care Centres GP Inc.

Long-Term Care Home and City
Arbour Creek Long-Term Care Centre, Hamilton

Lead Inspector
Lisa Vink #168

Additional Inspector(s)
Phyllis Hiltz-Bontje #129

Inspector Digital Signature
Lisa Vink
Digitally signed by Lisa Vink
Date: 2022.06.30 13:58:04 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following dates: June 10, 13,14,15,16,17, 20, 22, 24, 27 and 28, 2022.

The following intakes were inspected:
- Log 09154-22 related to falls prevention and management;
- Log 09163-22 related to falls prevention and management;
- Log 015139-21 for Follow-up Inspection (FUI) related to Compliance Order (CO) #001 from Inspection Report #2021_868561_0007 for Long-Term Care Homes Act, 2007, section (s.) 91 (1) related to resident charges;
- Log 015138-21 for FUI related to CO #002 from Inspection Report #2021_868561_0007 for Ontario Regulation (O. Reg.) 79/10, s. 51 (2) related to continence care and bowel management; and
- Log 015140-21 for FUI related to CO #003 from Inspection Report #2021_868561_0007 for O. Reg. 79/10, s. 90 (1) related to maintenance services.

Long-Term Care Consultant and Environmental Inspector, Bernadette Susnik #120 participated in this inspection remotely.

Inspectors Adiilah Heenaye Sumser #740741 and Waseema Khan #741104 participated in this inspection as observers and in supervised inspection activities.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 91 (1) 4	2021_868561_0007	001	#168
O. Reg. 79/10	s. 51 (2) (h)	2021_868561_0007	002	#168
O. Reg. 79/10	s. 90 (1) (b)	2021_868561_0007	003	#168

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

- Continence Care
- Falls Prevention and Management
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION – PLAN OF CARE

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 29 (3) 10

The licensee failed to ensure a resident's plan of care was based on an interdisciplinary falls risk assessment.

Rationale and Summary

A fall risk assessment identified that a resident was at risks for falls. The completed assessment and the clinical record indicated there was no evidence that other disciplines participated in the assessment.

The Physiotherapist (PT) confirmed they did not participate in the falls risk assessment that was completed for a resident.

The Director of Care (DOC) confirmed that the licensee's policy identified as "Falls Risk Assessment Policy", did not direct that the assessment was to be completed with an interdisciplinary focus.

The DOC acknowledged other disciplines did not participate in the falls risk assessment completed for a resident.

There was an increased risk that discipline specific issues that contributed to a resident's risk for falls, may not be managed when other disciplines did not participate in the assessment of risk to a resident.

Sources: Fall Risk Assessment for a resident, Falls Risk Assessment Policy and interviews with the PT and DOC.

WRITTEN NOTIFICATION - REPORTS REGARDING CRITICAL INCIDENTS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 115 (3) 4

The licensee failed to ensure that the Director was informed of two incidents that caused an injury to a resident for which a resident was taken to a hospital and resulted in a significant change in their health status, no longer that one business day after the occurrence.

Rationale and Summary

a) The home submitted a CIS report to the Director for an incident that occurred involving a resident. The CIS report indicated that the incident caused injury to a resident for which they were transferred to the hospital and resulted in a significant change in their health status. The DOC confirmed the CIS report had not been submitted to the Director within one business day as was required.

b) The home submitted a CIS report to the Director for an incident that occurred involving a resident. The CIS report indicated that the incident caused injury to a resident for which they were transferred to the hospital and resulted in a significant change in their health status. The DOC confirmed the CIS report had not been submitted to the Director within one business day as was required.

Failure to notify the Director of an incident within the required period of time did not pose a risk to the resident 's care or safety.

Sources: CIS reports and interview with the DOC.

WRITTEN NOTIFICATION – FALLS PREVENTION AND MANAGEMENT

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee failed to comply with their strategy to monitor a resident related to a potential head injury after they sustained a fall.

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Rationale and Summary

In accordance with O. Reg 246/22, s.11 (1) (b) the licensee was required to ensure that the falls prevention and management program, had in place strategies to monitor residents, and that the strategy was complied with.

Specifically, staff did not comply with the strategy to monitor a resident for a head injury in accordance with the Head Injury Routine policy. The policy directed that following a head injury or a suspected head injury a resident's vital sign would be checked and recorded on the Neurological Flow Sheet every 15 minutes for one hour, every 30 minutes for two hours and every hour for five hours. The policy also directed that staff were to document the monitoring of a residents' level of consciousness in the interdisciplinary progress notes.

A resident experienced a fall that resulted in an injury and staff initiated the monitoring of the resident on the Neurological Flow Sheet.

The Neurological Flow Sheet indicated staff did not document they monitored a resident every 15 minutes for the first hour, every 30 minutes for the following two hours or every hour for the following five hours, in accordance with the policy.

The progress notes identified staff had not documented on a resident's level of consciousness, in accordance with the policy.

The DOC confirmed that staff had not completed the monitoring of a resident in accordance with the direction identified in the Head Injury Routine policy.

There was an increased risk that symptoms of a head injury would not be identified and treated when staff did not complete monitoring of a resident as required following the fall.

Sources: A resident clinical notes and Neurological Flow Sheet, licensee's "Head Injury Routine" policy and an interview with the DOC.