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

Hamilton District
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Original Public Report

Report Issue Date: February 14, 2023	
Inspection Number: 2023-1414-0002	
Inspection Type: Critical Incident System	
Licensee: Rykka Care Centres GP Inc.	
Long Term Care Home and City: Arbour Creek Long-Term Care Centre, Hamilton	
Lead Inspector Emily Robins (741074)	**Inspector Digital Signature** Emily C Robins Digitally signed by Emily C Robins Date: 2023.02.28 08:24:22 -05'00'
Additional Inspector(s) Ruzica Subotic-Howell (548)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 23-27, 2023 (on-site) and January 31-February 1, 2023 (off-site).

The following intake(s) were inspected:

- Intake #00004929 related to the fall of a resident resulting in left hip fracture.

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

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

The licensee has failed to ensure that two pieces of equipment used to prevent and reduce injury from falls were provided to a resident as set out in their plan of care.

Rationale and Summary

A resident's plan of care specified that they required a certain piece of equipment to prevent and reduce injury from falls. The resident's electronic Treatment Administration Record (e-TAR) specified that they required a second piece of equipment to prevent and reduce injury from falls.

On two separate days in January 2023, it was observed that the first piece of equipment required was not provided as set out in their plan of care. A Personal Support Worker (PSW) acknowledged this and identified that the second piece of equipment required was not provided either. Another PSW indicated that the resident was bathed earlier that day and the PSW observed that the second piece of equipment was not in place when they were picked up for their bath. The Director of Care (DOC) indicated that it was the home's expectation that the care set out in the plan of care be provided and that in the case of these two pieces of equipment, the plan of care was not followed.

The resident's e-TAR for January 2023 demonstrated that a Registered Practical Nurse signed off on the second piece of equipment being in place the same morning it was observed that it was not.

As a result of the care set out in the plan of care not being provided to the resident, they were at increased risk of a fall or further injury.

Sources: Resident care plan, observations of resident, interviews with PSWs and DOC and review of the resident's e-TAR.

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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that routine precautions were to be followed in the IPAC program, which included (e) (ii) engineering controls, such as barriers.

The home utilized the questions included in Public Health Ontario's COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes in their own self-assessment tool. This tool includes item #1.6 "If screener present, they are wearing a medical mask and also eye protection if not behind a barrier".

On a day in January 2023 one staff person and two visitors were observed to be screened into the home by a screener. The screener was not sitting behind a barrier nor wearing eye protection at the time.

During an interview with the Admissions Coordinator on a different day in January 2023 it was noted that this staff person, who was responsible for screening staff and visitors into the home (including to provide them with a mask) at the time, was not sitting behind a barrier nor wearing eye protection.

On another day in January 2023 the Inspector was screened into the nursing home by the same screener and given a mask. The screener was not sitting behind a barrier nor wearing eye protection at the time.

In an interview with the IPAC Lead they indicated that it is the expectation for staff screening staff and visitors into the home to either be sitting behind a barrier or wearing eye protection. They were advised of the Inspectors observations at the time of the interview.

Failure to comply with the IPAC standard, specifically to use engineering controls such as barriers where required, increased the risk of pathogen transmission to residents of the home.

Sources: Public Health Ontario's COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes, observations of the home's screening station, interview with IPAC Lead.

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