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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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: November 6, 2023

Inspection Number: 2023-1414-0006

Inspection Type:
Complaint
Critical Incident
Follow Up

Licensee: Rykka Care Centres GP Inc.

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

Lead Inspector	**Inspector Digital Signature**
Brittany Wood (000763)	Brittany Wood Digitally signed by Brittany Wood Date: 2023.11.17 15:27:34 -05'00'

Additional Inspector(s)
Yuliya Fedotova (632)

INSPECTION SUMMARY

The inspection occurred onsite for the following date(s): October 18-20, 2023, and October 23-26, 2023

The following intake(s) was inspected in the Critical Incident (CI) section:
Intake #00096606/CI#2930-000021-23 and Intake #00089591/CI#2930-000010-23 related to falls prevention and management.

Intake: #00091191 - Follow-up Compliance Order (CO) #01 from inspection #2023-1414-0004 regarding to O. Reg. 246/22 - s. 11 (1) (b) relating to Policy (Agency Utilization).
Intake: #00091192 - Follow-up Compliance Order (CO) #02 from inspection #2023-1414-0004 regarding O. Reg. 246/22 - s. 51. Certification of Nurses.

The following intake was completed in this inspection:
Intake #00087802/CI#2930-000006-23 related to falls prevention and management.

The following intake was inspected in the compliant section:
Intake #00097732 related to prevention of abuse and neglect, nutritional and hydration programs,

continence care and bowel management, falls prevention and management, and resident care services.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1414-0004 related to O. Reg. 246/22, s. 11 (1) (b) inspected by Brittany Wood (000763)

Order #002 from Inspection #2023-1414-0004 related to O. Reg. 246/22, s. 51 inspected by Brittany Wood (000763)

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to a resident related to providing an assistive aid as specified in their plan.

A) It was observed a resident was drinking fluids from regular drinking cups, which were provided at lunch and for a morning snack.

Plan of care for the resident indicated that they required an adaptive aid. During an interview, the Food

Service Manager confirmed that the resident required and would be provided with that adaptive aid.

It was observed that the resident was provided with the adaptive aid during lunch time.

Sources: Resident's plan of care; observations; interview with the Food Service Manager. **[632]**

Date Remedy Implemented: October 23, 2023.

B) A plan of care for a resident directed staff to offer a specific intervention.

The Interim DOC indicated that the resident should receive that intervention as per their plan of care. During an interview a staff indicated that a resident was provided with the specific intervention.

Sources: Resident's plan of care; interviews with staff and the Interim DOC. **[632]**

Date Remedy Implemented: October 26, 2023

WRITTEN NOTIFICATION: Menu Planning

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (b)

The licensee failed to ensure that the resident was offered a minimum of, (b) a between-meal beverage in the afternoon.

Rationale and Summary
It was observed that a resident was not provided fluids during afternoon snacks distribution.

Plan of care for the resident directed staff to pour and serve fluids to the resident during snack and mealtimes, even they stated they did not want the drink.

The Interim Director of Care (DOC) indicated that it was expected that drinks were provided during the second round of drinks distribution to residents, who were sleeping by leaving the drinks on the residents' side tables.

Sources: Plan of care; observations; interview with the Interim DOC. **[632]**

WRITTEN NOTIFICATION: Plan of care

NC #002 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 the care set out in the plan of care for resident #003 was provided to the resident as specified in the plan.

Rationale and Summary
A resident's fall prevention plan of care indicated that a specific equipment was to be attached to their mobility device and in working order. The resident was observed to be using their mobility device without the specified equipment.

Failure to ensure the care set out in the plan of care regarding the resident's specified equipment led to an increased risk of the resident's safety for falling.

Sources: A resident's clinical records, observations and interview with staff. **[000763**]