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: March 19, 2024	
Inspection Number: 2024-1414-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Rykka Care Centres GP Inc.	
Long Term Care Home and City: Arbour Creek Long-Term Care Centre, Hamilton	
Lead Inspector Barbara Grohmann (720920)	**Inspector Digital Signature** Barbara Grohmann 2024.03.27 08:14:31 -04'00'
Additional Inspector(s) Brittany Wood (000763)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 6-8, 11-13, 2024

The following intakes were inspected during this complaint inspection:

- Intake: #00107199, was related to skin and wound care, and
- Intake: #00107513, was related to falls prevention and management and continence care.

The following intakes were inspected during this Critical Incident (CI) inspection:

- Intake: #00107085, (CI 2930-000007-24) was related to falls prevention and management.

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

Falls Prevention and Management
Infection Prevention and Control
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff who provide direct care to the resident related to altered skin integrity.

Rationale and Summary
A. During a short period of time, a resident developed several different areas of altered skin integrity. Multiple nursing treatments were initiated to address each specific area; however, one nursing treatment did not include the location on the resident where it was to occur.

B. A resident developed altered skin integrity. The physician prescribed a medicated

product to be applied to the affected area. The resident's electronic treatment administration record (eTAR) was updated with instructions on how to clean the affected area, and apply the medicated product along with a scheduled for the treatment. A month later, the treatment using the medicated product was discontinued and replaced with a treatment using a different product; however, the original medicated product was not discontinued until two weeks later. A review of the administration records showed that registered staff continued to sign off on applying the medicated product, after the treatment was discontinued and while they were also signing off on performing the wound care using the second product.

A registered practical nurse (RPN) stated that they typically alerted the doctor when a treatment product had changed, so the previous one could be discontinued with a doctor's order. They agreed that the electronic medical administration records (eMAR) and eTAR orders were confusing when the original medicated product was not discontinued when the treatment changed and it was no longer needed.

The Assistant Director of Care (ADOC) explained that when the registered staff signed off medication or treatment on the eMAR/eTAR, the check mark indicated the medication and/or treatment was administered. The Executive Director (ED) acknowledged that having a medicated product active after the treatment using that product was discontinued could be confusing.

Failure to ensure that the eMAR/eTAR provided clear direction regarding wound care, including the location, frequency and product, had the potential to create confusion among the registered staff.

Sources: resident's clinical records; interviews with the ED, ADOC and other staff. [720920]

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)
Plan of care
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.

The licensee has failed to ensure that care set out in the plan of care was provided for a resident as specified in the plan related to altered skin integrity.

Rationale and Summary
A resident returned from hospital following a surgery.

i. The resident's eTAR was updated, requiring registered staff to complete a health status note on every shift. The task was discontinued 13 days after it was started. A review of Point Click Care (PCC) records identified that a health status progress note was only completed on 15/37 shifts during that time frame.

ii. The resident's eTAR required registered staff to complete care to the surgical incision every three days and then write a skin and wound note indicating the status of healing. A review of PCC records between identified that only four out of the required 15 notes were completed after care was signed off by the registered staff.

The ADOC acknowledged that registered staff were expected to follow the directions as outlined in the eTAR.

Failure to complete the required progress notes may have resulted in the health care team being unaware of changes in the resident's condition that may have

needed addressing.

Sources: resident's clinical records; and interview with the ADOC. [720920]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee has failed to ensure that the outcomes of the care set out in the plan of care were documented.

Rationale and Summary
A resident's plan of care indicated an intervention for incontinence that required frequent checks.

A personal support worker (PSW) stated that documentation would be completed after care was provided to the resident. The Kardex indicated that no documentation related to that intervention was made for a specific day and shift.

The Director of Care (DOC) reviewed the resident's Kardex and acknowledged the care was not documented.

Failure to document care placed the resident at risk as there was no documentation to confirm care was provided and unable to determine the care for the resident was completed.

Sources: resident's clinical records, interviews with staff. [000763]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that the resident is reassessed and the plan the care revised when the resident's needs change or care set out in the plan is no longer necessary.

Rationale and Summary
A resident's plan of care indicated that the resident was to wear appropriate footwear. During observations, it was noted that the resident was not wearing proper footwear.

A PSW confirmed that the resident was wearing a supportive device on their foot due to recent changes in condition. A registered nurse acknowledged the resident was not wearing an appropriate form of footwear. The ADOC confirmed that the resident's care needs were not updated in their care plan and that it should reflect the current needs of the resident.

Failure to ensure that the care set out in the plan of care regarding the resident was

updated could potentially lead to an increase risk to the resident's safety.

Sources: resident's clinical records, observation and interviews with staff. [000763]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)
Infection prevention and control program
s. 23 (4) Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program.

The licensee has failed to ensure that the home had an infection prevention and control (IPAC) Lead whose primary responsibility was the home's IPAC program.

Rationale and Summary
The home's IPAC Lead submitted their resignation, giving the home four weeks' notice. The DOC explained that after the IPAC Lead resigned, several management and other staff were taking on some of the duties of the IPAC Lead role, until the position could be filled permanently.

The ED acknowledged that currently the home does not have one staff member whose primarily responsibility was the home's IPAC program. They stated that interviews have been conducted and they have a qualified candidate in mind, but an offer of employment has not yet been made. If the successful candidate accepted the offer, the ED was unsure when they would assume the role in the home.

Failure to have an IPAC Lead whose primary responsibility was the IPAC program may result in some aspects of the IPAC program being overlooked.

Sources: resignation letter; interview with the ED, DOC and other staff. [720920]