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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: January 10, 2024
Inspection Number: 2023-1414-0008
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	**Inspector Digital Signature**
Dusty Stevenson (740739)	Dusty Stevenson Digitally signed by Dusty Stevenson Date: 2024.02.06 15:59:07 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 18-21, 28-29, 2023 and January 3-4, 2024

The following intake(s) were inspected:

- Intake #00100651/CI#2930-000032-23 related to falls prevention and management
- Intake #00102751 complainant related to skin and wound care, when licensee shall discharge.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Based on assessment of resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care
Based on assessment of resident
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee failed to ensure an intervention for a resident was based on their assessed needs.

Rationale and summary

A resident's electronic medication administration record (eMAR) indicated a verbal order was made to implement an intervention. The intervention was provided daily according to the eMAR and a staff confirmed the resident received this intervention daily.

The resident's progress notes and assessments were reviewed and there was no

assessment completed when this intervention was implemented.

The home's dietitian indicated an assessment should have been completed prior to implementing.

As a result of not conducting an assessment when implementing an intervention for the resident the home failed to ensure the intervention was based on the assessed needs of the resident.

Sources: interview with staff, resident's clinical records [740739]

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9)
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

The licensee failed to ensure a resident's provision, outcomes and effectiveness of care were documented.

Rationale and summary

On a day in January, 2020, a resident's minimum data set (MDS) indicated they required a specific care.

A staff member indicated that if a resident was assessed to require a specific care then the care and refusal of, should be documented by staff each shift.

The resident's care plan and Kardex did not indicate they received the care, and documentation was not made of the care until it was added on a day in October, 2023.

Three staff members indicated they completed the care daily and at times the resident was not compliant with or refused the care.

A staff member reviewed the residents care documents with Inspector #740739 and acknowledged the care was not documented.

Failing to document care placed the resident at risk as there was no documentation to confirm care was provided, and thereby unable to determine compliance with and effectiveness of care for the resident.

Sources: resident's clinical records, interviews with staff. [740739]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
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;

The licensee failed to revise a resident's plan of care when care needs changed.

Rationale and summary

According to a resident's MDS, they required increased assistance for an area of care.

The resident's care needs changes, the care plan/Kardex did not change to reflect the increased need for assistance for an area of care.

A staff member indicated that when the resident's care needs changed, their care plan should have been updated so staff were aware.

Failing to revise a resident's care plan when their care needs changed put them at risk of not receiving the level of assistance they required.

Sources: resident's clinical records, interview with staff [740739]

WRITTEN NOTIFICATION: Weight changes

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 2.
Weight changes
s. 75 Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 2. A change of 7.5 per cent of body

weight, or more, over three months.

The licensee failed to assess a resident when they experienced a significant weight change.

Rationale and Findings

A resident's clinical records indicated they experienced a significant weight change.

A weight assessment was not completed for the months they experienced the significant weight change.

The home's weight monitoring policy stated that an interdisciplinary team was to complete weight change reviews for all residents with significant weight variances and determine if further assessment was necessary by the home's registered dietitian (RD).

The home's RD indicated their process for weight change assessments is to complete them by referral and perform a review quarterly. A review of the resident's records indicated that a referral was not completed for a weight assessment when the resident experienced a significant weight change.

A staff member reviewed the resident's records with Inspector #740739 and indicated that an assessment should have been completed for the resident when they had a significant weight change.

Failing to complete an assessment for the resident when they experienced a significant weight change and not referring to the RD placed the resident at increased nutritional risk.

Sources: interview with RD and staff, resident's clinical records, Resident Weight Monitoring Policy (RCS C-25; reviewed March 3, 2023) [740739]

WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (1) (a)
Requirements on licensee before discharging a resident
s. 161 (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or

The licensee failed to notify a resident or their substitute decision maker (SDM) that the resident would be discharged from the home following a medical leave of greater than 30 days.

Rationale and Summary

A resident was sent to hospital on a day in October, 2023. The resident's SDM communicated to Inspector #740739 that on a day in November, 2023, they were informed by the dietitian at the hospital that the resident had been discharged from the home.

In an interview with the Executive Director of the home, they confirmed that they did not inform the resident or their SDM they would be discharged from the home

following a 30 day medical leave, despite knowing prior to the discharge date that they would not be able to accommodate the medical needs of the resident.

As a result, the resident was not provided the appropriate communications for discharge.

Sources: resident's clinical records, interview with Executive Director and resident's SDM [740739]