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: July 7, 2023	
Inspection Number: 2023-1414-0005	
Inspection Type: Complaint Follow up	
Licensee: Rykka Care Centres GP Inc.	
Long Term Care Home and City: Arbour Creek Long-Term Care Centre, Hamilton	
Lead Inspector Stephanie Smith (740738)	**Inspector Digital Signature** Stephanie D Smith Digitally signed by Stephanie D Smith Date: 2023.07.24 10:03:34 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 28-30, and July 4, 2023.

The following intake(s) were inspected:

- Intake: #00085082 - Follow-up #: 1 - LTCHA, 2007 S.O. 2007, c.8 - s. 76 (2) 10, Compliance due date (CDD): May 17, 2023.
- Intake: #00086974 - Complaint regarding alleged sexual abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1414-0003 related to LTCHA, 2007 S.O. 2007, c.8, s. 76 (2) 10. inspected by Stephanie Smith (740738)

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

Medication Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards

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 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when the resident's care needs changed.

Rationale and Summary
A resident's room was observed to have an intervention present to prevent potential responsive behaviours. There was no documentation within the resident's care plan that the resident required use of the intervention. The Director of Care (DOC) acknowledged that the intervention should be documented in the care plan.

Failure to ensure that the resident's plan of care was revised to include use of the intervention, put the resident at risk for potential responsive behaviours.

Sources: Observations of the resident's room, the resident's care plan, interview with DOC. [740738]

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two residents, including identifying and implementing interventions.

Rationale and Summary

A resident had a history of responsive behaviours and the home used two interventions to reduce the potential for these behaviours.

On a date in 2023, it was documented that the resident exhibited a responsive behaviour towards another resident. There was no injury to either resident. On a later date in the same month, there was a similar incident where the resident exhibited a similar responsive behaviour toward the same resident. There was no injury to either resident after this incident.

The DOC stated that they were not made aware of the first incident until seven to ten days later. They stated that after that incident, they believed that a new intervention was introduced to prevent possible responsive behaviours from occurring. There was no documentation to corroborate that this intervention was identified and/or implemented. Additionally, the DOC acknowledged that the other intervention was only effective when staff observed the resident's responsive behaviours. The intervention as indicated in the resident's care plan, was not implemented by staff in either incident.

Failure to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between the two resident's put both resident's safety at risk.

Sources: Resident's clinical records, care plans, and progress notes, the home's investigation notes, interviews with DOC and other staff. [740738]