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 5, 2024
Inspection Number: 2024-1414-0003
Inspection Type: 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**
Olive Nenzeko (C205)	Olive Mameza Nenzeko Digitally signed by Olive Mameza Nenzeko Date: 2024.07.16 08:34:15 -04'00'

Additional Inspector(s)
Jagmail Brar (000845)
Carla Meyer (740860)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 18-21, 25, 26, 2024

The following intake(s) were inspected:

- Intake: #00109585/CI #2930-000010-24 related to Food, Nutrition and Hydration.
- Intake: #00114350/CI #2930-000018-24 related to Disease Outbreak.
- Intake: #00115650/CI #2930-000020-24 related to Skin and Wound Prevention and Management.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control

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)
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the *Health Protection and Promotion Act* were followed in the home.

The Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings issued by the Ministry of Health, effective April 2024,

stated that Alcohol-Based hand rubs (ABHR) are the first choice for hand hygiene when hands are not visibly soiled and ABHR must not be expired.

Rationale and Summary
Inspector #C205 observed two bottles of ABHR on one resident home area, which was also verified by the Infection Prevention and Control (IPAC) Lead. The two expired bottles of ABHR were replaced by non-expired ones the same day.

Sources: Observation on Clayton House; Ministry of Health Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (effective April 2024).
[C205]

Date Remedy Implemented: June 18, 2024

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident , immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
The Interim Director of Care (IDOC) conducted a wound audit and found that the resident had received improper wound care from two staff. The resident was sent to the hospital the same day for further wound care.

A Critical Incident (CI) #2930-000020-24 was submitted to the Director by the Long-Term Care (LTC) home on an identified about the above incident.

The Interim Director of Care (IDOC) confirmed they became aware of the above incident the day the wound audit was completed ; however, it was reported to the Director several days late.

Sources: CI #2930-000020-24; Resident's clinical record; Home's investigation notes; Interview with IDOC.
[C205]

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The Licensee has failed to ensure that a resident exhibiting altered skin integrity including wounds received immediate treatment and interventions to reduce or

relieve pain, promote healing, and prevent infection, as required.

Rationale and Summary
Resident returned from the hospital after undergoing surgery. The resident's Treatment Administration Record (TAR) indicated weekly assessment of the surgical incision, capture photo and complete assessment using skin and wound application every Monday every day shift. A physician's order prescribed the same day stated daily wound check, keep wound clean and dry, paint with iodine clean and pat dry, then apply new dressing.

On a specific day, the Interim Director of Care (IDOC) conducted a wound audit and identified that improper wound care had occurred. The home's investigation notes revealed that two staff did not change the resident's wound dressing as per the physician's order and did not complete a skin and wound assessment as required. One staff had taken the picture of the resident's wound during the day shift but did not change the resident's dressing even though the staff had noted the wound to be possibly infected and oozing exudate. Wound dressing change was done in the evening by another staff who also notified the physician. The resident was transferred to hospital that same day for further wound care.

Failure to provide immediate skin and wound care treatment and intervention, the resident did not receive the required care in a timely manner and was sent to hospital for further wound care.

Sources: Resident's clinical record; Home's investigation notes; Interview with staff and others.
[C205]

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a written complaint made to the licensee concerning the care of a resident was investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

Rationale and Summary
Resident 's family member submitted an email complaint to the home expressing their dissatisfaction with the resident's wound care and the negative impact it had on the resident.

The IDOC stated that the complaint was immediately investigated and that they did not provide a written response to the family member.

Sources: Email complaint; 2024 complaint binder; Interview with IDOC.
[C205]

WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Medication management system

s. 123 (3) The written policies and protocols must be,

(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that written policies and protocols that were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt and administration of all drugs used in the home, and that those that were developed were implemented for a resident.

Specifically, the policy "Transcribing Physician and/or Nurse Practitioner Orders" revised March 14, 2024, which was included in the medication administration policy/procedure, was not implemented.

The policy stated that the physician, nurse practitioner (NP) and registered dietician (RD) who had written the order or the nurse who had taken the phone order shall flag (red tab) in all charts with new orders. Registered staff were to verify that the physician, NP or RD order was complete, or immediately follow-up with the physician, NP or RD to obtain a complete order to include the frequency of administration as well as any important instructions.

Rationale and Summary

A staff received and transcribed the physician's order for treatment of the resident's wound. The order stated to check the resident's wound daily, keep the wound clean and dry, paint with iodine, clean and pat dry, then apply new dressing. The staff

incorrectly transcribed the order on the Treatment Administration Record (TAR) as every three days and was unable to explain where this information came from.

IDOC acknowledged that the staff did not follow the home's Transcribing Physician and/or Nurse Practitioner Orders policy when they did not clarify the order with the physician initiating the order since it was unclear how frequently the wound dressing was to be changed. IDOC stated that the order was later changed to reflect the physician's order.

Failing to adhere to the home's policy, the resident did not receive their prescribed treatment on time.

Sources: Physician's order; Transcribing Physician and/or Nurse Practitioner Orders policy (revised March 14, 2024); Investigation notes; Interview with staff.
[C205]