Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 26, 2015	2015_248214_0001	H-001509-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

GARDEN CITY MANOR
168 Scott Street St. Catharines ON L2N 1H2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 6, 2015

During the course of the inspection, the inspector(s) spoke with the Director of Care(DOC); Associate Director of Care(ADOC); Environmental Services Manager (ESM). The inspector also reviewed relevant clinical records, policies and procedures and observed equipment in the home.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Personal Support Services
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

A review of resident #100's written plan of care with an identified date of October 2014, indicated under bathing that the resident required two person's physical assistance. A review of the resident's kardex indicated that the resident required one person physical assist. An interview with the DOC confirmed that the plan of care did not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A review of resident #100's written plan of care with an identified date of October 2014, indicated under bathing that the resident uses a mechanical lift for transfers into the tub. A review of the resident's kardex indicated that the resident requires full staff assistance (total dependence) for bathing and that they prefer a bath: specialized bathing equipment is used due to impaired mobility, for comfort and safety. The DOC confirmed that the resident is no longer bathed in the tub; no longer uses the specialized bathing equipment and has been receiving an alternative to bathing in the tub since an identified date in August 2014. The DOC confirmed that the resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and to 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 the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A review of the home's policy titled, "Bath Lifts, Tub Chair and Shower Commodes" (LTC-K-80 and dated August 2012), indicated under National Operating Procedure, that the following would be completed:

i) Residents will be assessed on admission, with significant change in condition and on referral, to ensure appropriate equipment is utilized.

A review of resident #100's clinical record indicated that on an identified date in October 2014, the resident was bathed using specialized bathing equipment. An interview with the ADOC confirmed that the home does not conduct an assessment on admission, with significant change in condition or on referral to ensure appropriate equipment is utilized for bathing.

ii) The Home will conduct monthly maintenance inspections on bathing equipment. All repairs to mechanical equipment will be done by the contracted vendor.

A review of resident #100's clinical record indicated that on an identified date in October 2014, they were bathed using specialized bathing equipment. An interview with the DOC and ESM confirmed that monthly maintenance inspections are not completed on bathing equipment, including the specialized bathing equipment used by this resident.

iii) A pre-start up safety inspection will be completed daily by the care staff prior to the first use of any bathing or showering equipment.

A review of resident #100's clinical record indicated that on an identified date in October 2014, while being bathed on specialized bathing equipment, the resident sustained a fracture to their lower limb. A review of the home's Internal Incident Investigation notes indicated that no start-up checklist was in the binder and that staff were checking boxes on a form with the wrong device name. A review of this pre-start-up checklist indicated that the checklist was for a shower chair (tub) and did not specify the specialized bathing equipment that was used by the resident. The DOC confirmed that the pre-start-up checklist did not specify that it was for the specialized bathing equipment and that the home currently did not have a pre-start-up checklist for this specified equipment. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A review of resident #100's clinical record indicated that on an identified date in October 2014, the resident was being bathed on specialized bathing equipment, with two staff present. During the bathing, staff rolled the resident onto their side and the resident verbalized pain to the right side of their lower body. Staff noticed that the resident's heel had slipped into a recessed area on the specialized bathing equipment and as a result, the resident sustained a fracture to their lower limb. An interview with the DOC confirmed that the resident's height was within the requirements of use for the specialized bathing equipment; however; the resident had slipped downwards and staff did not ensure that safe positioning techniques were used while bathing the resident. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 218. Orientation For the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training shall be provided:
1. The licensee's written procedures for handling complaints and the role of staff in dealing with complaints.
2. Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.
3. Cleaning and sanitizing of equipment relevant to the staff member's responsibilities. O. Reg. 79/10, s. 218.

Findings/Faits saillants :

1. The licensee failed to ensure that for the purposes of paragraph 11 of subsection 76 (2) of the Act, the following were additional areas in which training was to be provided: Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that was relevant to the staff member's responsibilities.

A review of resident #100's clinical record indicated that on an identified date in October 2014, the resident was being bathed on specialized bathing equipment, with two staff present. During the bathing, staff rolled the resident onto their side and the resident verbalized pain to the right side of their lower body. Staff noticed that the resident's heel had slipped into a recessed area on the specialized bathing equipment and as a result, the resident sustained a fracture to their lower limb. A review of the home's Internal Incident Investigation form completed on an identified date in October 2014, indicated that the date of last training on this assistive aid for the staff involved in the incident was "a few years". An interview with the ADOC confirmed that no training records for the use of the specialized bathing equipment for the staff involved in this incident could be located in the home. [s. 218. 1.,s. 218. 2.,s. 218. 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for the purposes of paragraph 11 of subsection 76 (2) of the Act, the following are additional areas in which training is to be provided: Safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that are relevant to the staff member's responsibilities, to be implemented voluntarily.

Issued on this 27th day of January, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.