Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 4, 26, Jun 7, 2011	2011_027192_0010	Complaint

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the physician, Food Services Supervisor, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

During the course of the inspection, the inspector(s) Reviewed medical records, observed meal service and care provision, and observed available supplies.

The following Inspection Protocols were used in part or in whole during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Dining Observation

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits sayants :

1. Residents exhibiting altered skin integrity did not receive weekly reassessments by a member of the registered nursing staff when clinically indicated.
A review of the Treatment Administration Records for April and May 2011 was completed for specified residents:
1. A specified resident has a change in skin integrity; no weekly assessment of the area could be located within the medical record.
2. A specified resident requires a prescribed cream to an area of altered skin integrity; no location for the area of altered skin integrity could be determined and no weekly assessment of the area could be located within the medical record.
3. A specified resident requires treatment to a rash twice daily; no weekly assessment of the area could be located within the medical record.
Discussion with the Wound Care Nurse indicated that she is responsible for wound assessments done weekly on residents with open pressure areas. Registered staff on the floor are responsible for assessment of other residents with altered skin integrity.

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 ensuring that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits sayants :

1. May 4, 2011, during observation of the meal service in the central dining room it is noted that home, furnishings and equipment are not always maintained in a safe condition and in a good state of repair.
a. In many places around the room, the flooring is pulling away from the wall where it joins the wall to make a baseboard.
b. The corner bead is off on the lower part of the short wall, on the north side of the room and the bare wall is showing.
c. The legs of the wooden chairs in the dining room appear soiled and are scarred with the finish having worn off.
2. May 4, 2011, during observation of lunch service on 2 South, it is noted that the home, furnishings and equipment are not kept clean and sanitary.
a. There is evidence of liquids having spilled down the sides of the steam table.
b. When the freezer door is opened it is noted that the area around the seal is black and mildew like in appearance.
c. The servery area is generally noted to be unclean. Inside of cupboards and drawers there is a noted accumulation of dirt and debris.
May 4, 2011, during observation of lunch service in the second floor central dining room it is noted;
a. The floor appears unclean, with large pieces of lint noted in the middle of the floor.
b. The windows on the north side of the dining room are soiled with spilled food.
c. The ceiling is soiled with food or fluid having been splashed across the ceiling.
d. Table legs on the majority of tables are soiled with dried food and spilled liquids with some noted to be rusting.
e. The railing surrounding the dining room is attached to the floor - it is noted that there is a build up of black dirt surrounding each post supporting the railing.
f. The steam table is noted to be soiled with spilled liquids.
During observation on 2 South it is noted that many of the ceiling tiles in the corridor are soiled with what appear to be dried liquid stains, some ceiling tiles are noted to be damaged with pieces missing and the surface peeling off the tile.

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 ensuring that, the home, furnishings and equipment are kept clean and sanitary and the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

Issued on this 29th day of June, 2011

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

Debora Saville