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

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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
Aug 6, 2015	2015_247508_0011	H-002415-15	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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 22, 23, 24, 25, 2015

This inspection was conducted concurrently with Critical Incident #H-001352-14

During the course of the inspection, the inspector(s) spoke with the Executive Director(ED), Acting Executive Director, Registered Dietitian(RD), Food Services Supervisor, Environmental Services Manager, Personal Support Workers (PSW), registered staff and residents. During this inspection the inspector toured the home, interviewed residents and staff, reviewed relevant policies and procedures, complaint log, maintenance records, trust accounts and resident clinical records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Pain
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **5 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs were fully respected and promoted.

Resident #003 was assessed by the Registered Dietitian (RD) as a high nutritional risk and it was identified that the resident required a certain amount of fluids to meet the resident's estimated needs.

A review of the resident's "Daily Fluid Intake" sheets from March to June, 2015, indicated that the resident did not meet the required fluid intake 14 days in April, 17 days in May and 14 days in June, 2015.

The RD indicated during an interview on June 24, 2015, that she had not been advised of the resident's inadequate intake. The RD and the Acting Executive Director stated during an interview that it is the home's expectation that nursing staff monitor residents intake of food and fluid and refer to the Nutrition Manager and the RD when residents are not meeting their daily intake requirements for three consecutive days.

Resident #003's nutritional needs related to fluid intake had not been met more that 50% of the time and there were 12 incidents of three or more consecutive days where the resident had not met the fluid intake requirements over a three month period.

It was confirmed by the RD and the Acting Executive Director during an interview on June 24, 2015, that resident #003's had not been cared for in a manner consistent with the resident's needs. [s. 3. (1) 4.]

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 the resident's rights to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs are fully respected and promoted, to be implemented voluntarily.

WN #2: 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. (3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care. 2007, c. 8, s. 6 (3).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #001 had unwitnessed falls over a two month period in 2015. On June 21, 2015, when the Inspector arrived at the home to conduct this inspection, the resident did not have a falls care plan. The following day, once this had been identified, a plan of care had been developed which included falls as a focus. The resident's plan of care identified the resident as a risk for falls and referred staff to "see FRAT score". This score which identified the level of risk for falls was not documented on the care plan.

Under the falls interventions, the staff were directed to check the resident to ensure resident safety and to document in Point of Care (POC). The frequency of these safety checks was not specified.

It was confirmed by the Acting Director of Care on June, 24, 2015, that the resident's plan of care did not set out clear directions to staff and others who provided care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident's plan of care covered all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational,

social, restorative, religious and spiritual care.

During this inspection, staff were interviewed by the Inspector on June 22, 2015, to identify what staff referred to for direction in providing care to residents. Registered staff indicated that they refer to the electronic care plan accessed in Point Click Care (PCC).

A review of the resident's care plan in PCC identified that the resident's care plan had only one focus, which was recreation. All other aspects of care had not been developed in the resident's care plan until after the Inspector arrived at the home to conduct an inspection.

It was confirmed by the Acting Executive Director on June 23, 2015, that resident #001's plan of care did not cover all aspects of care including medical, nursing, personal support, nutritional, dietary, social, restorative, religious and spiritual care. [s. 6. (3)]

3. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001 was identified as a choking risk and had difficulty swallowing. On an unidentified date in 2015, resident #001 was admitted to hospital due to an infection and dehydration. The resident was assessed by a Speech and Language Pathologist and had a swallowing assessment done while in the hospital.

The resident was re-admitted back to the home and the resident's diet texture was changed due to an increased risk of choking. After the resident was re-admitted back to the home, staff gave the resident regular thin fluids with dinner which was not the consistency prescribed. This had been identified by a visitor and confirmed with the registered nursing staff on duty.

It was confirmed by the Acting Director of Care that care set out in the resident's plan of care was not provided as specified in the plan. [s. 6. (7)]

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 the plan of care sets out clear directions to staff and others who provide direct care to residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #001 had an unwitnessed fall on an unidentified date in 2015. During the initial assessment conducted by registered staff, the staff indicated that the resident had pain which was described as severe. The resident was transferred to hospital for further assessment and returned to the home later that day. A fracture had been ruled out.

The next afternoon, the resident received analgesics due to complaints of pain. The next morning, the resident complained of being sore all over. Analgesics were again administered. That same afternoon, the resident was discovered partially out of bed. The next morning, resident #001 complained of pain and received analgesics.

A review of the resident's clinical record, indicated that the resident had not been assessed using a clinically appropriate assessment instrument specifically designed for this purpose when their pain was not relieved by initial interventions. This information

was confirmed by the Acting Executive Director on June 24, 2015. [s. 52. (2)]

2. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate instrument specifically designed for this purpose.

Resident #002 started complaining of pain on an unidentified date in 2014 and analgesics were administered. Later that evening, the resident continued to have pain and received another dose of the analgesic. The registered staff had documented that the earlier dose of analgesics was not effective and that the resident had complained of pain most of the evening.

The following day, the resident continued to complain of pain and it was documented that the medications administered throughout the day were ineffective. The resident continued to complain of pain and the Physician ordered a routine analgesic to manage the resident's pain.

The following day, the Physician further assessed the resident and ordered a topical analgesic in addition to the regularly scheduled analgesics. An x-ray and other diagnostic tests were also ordered.

The resident continued to have on going complaints of pain until the resident was transferred to hospital for further assessment. Later that evening, the resident returned to the home and it had been determined through an x-ray that the resident had a fracture and narcotics were ordered to manage the resident's pain.

The resident's pain was not assessed using a clinically appropriate instrument designed for this purpose until eight days after the initial complaints of pain.

It was confirmed by the Acting Executive Director that when the resident's pain was not relieved by initial interventions, the resident was not assessed using a clinically appropriate instrument specifically designed for this purpose until nine days after the onset of her back pain. [s. 52. (2)]

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 when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment specifically designed for this purpose, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including, resident bedrooms, including floors, carpets, furnishings, contact surfaces and wall surfaces.

During this inspection, the Inspector toured the home including resident bedrooms and resident bathrooms, common areas and observed furnishings. It was identified on June 22, 2015, that in a resident's room, crumbs were scattered on the floor under the resident's bed. Behind the two sinks in the resident's bathroom, where the sink attaches to the counter, a dark brown substance was present.

In a resident's bathroom, dust was observed in the vent above the toilet. In another resident's room, it was observed that there was a dried sticky substance on the floor near and under the resident's bed.

During a tour later in the day on June 22, 2015, with the Environmental Services Manager (ESM), the ESM confirmed that these identified rooms had not been cleaned as expected. [s. 87. (2) (a)]

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 procedures are developed and implemented for cleaning of the home, including, resident bedrooms, including floors, carpets, furnishings, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident had fallen, the resident was assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #001 was identified as a high risk for falls on an unidentified date in 2014, and a medium risk for falls on an unidentified date 2015. In 2015, resident #001 had a change in condition and was transferred to hospital for further assessment. The resident was hospitalized due to an infection and dehydration. The resident was re-admitted back to the home and had an unwitnessed fall within 24 hours of being re-admitted to the home.

Two days later, resident #001 was discovered on the side of the bed, then less than two week later, resident #001 was discovered by staff half way from the bed to the floor.

A review of the resident's clinical record indicated that the resident had not been assessed using a clinically appropriate assessment instrument that was specifically designed for falls after any of these falls.

It was confirmed by the Acting Executive Director that resident #001 had not been assessed, when required, using a clinically appropriate assessment instrument that was specifically designed for falls after these identified falls in May and June, 2015. [s. 49. (2)]

Issued on this 14th day of August, 2015

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

Original report signed by the inspector.