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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 26, 2016	2015_189120_0100	002769, 023830, 035078-15	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

BERNADETTE SUSNIK (120)

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): December 29 & 30, 2015

The inspection was completed in response to concerns related to an identified resident's dietary interventions, the processing and cold holding of perishable snacks and housekeeping services.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Full-Time Food Services Manager (FSM #001), Part-Time Food Services Manager (FSM #002), Registered Dietician (RD), Associate Director of Care (ADOC), Environmental Services Supervisor, dietary staff and housekeeping staff.

During the course of the inspection, the inspector toured the home (random resident rooms, common spaces, tub/shower rooms), visited the kitchen and observed the storage of refrigerated perishable snacks for residents, reviewed housekeeping schedules and routines, reviewed an identified resident plan of care, assessments and progress notes and observed two lunch time meal services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Food Quality
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee did not ensure that an identified resident was re-assessed and the plan of care reviewed and revised at any time when the resident's care needs changed and when the care in the plan was not effective.

A) Resident #101 was admitted to the home in mid 2015 and was assessed initially with a high risk nutritional profile. The nutritional interventions documented in the resident's profile included supervision after set-up at meals, intermittent assistance with cutting up soft solid foods and verbal cueing to continue to eat or pick up utensils. This was added to the resident's care plan. A note was also made in the nutritional profile that they had progressive vision problems. The resident's care plan (available to all direct care staff) did not include any interventions or strategies to address their progressive vision issues. The resident identified several times after admission that they were having difficulty seeing their plate or food and needed assistance completing their meal. However, the care plan was not reviewed or revised to include any additional interventions or to amend existing interventions for the resident's "self-performance" eating goals.

B) According to documentation made by registered staff, approximately 4 weeks after admission, the resident identified to a staff member and a co-resident that they required more assistance with eating and were having difficulty seeing their food. However, no re-assessment was completed to determine whether the interventions included in the plan of care were in fact effective and continued to meet the resident's needs.

In August 2015, a complaint was received by a co-resident who sat with the resident at meal times with concerns that the resident was not getting the assistance they required during their meals. Documentation made by registered staff throughout the month of August 2015 revealed that the resident continued to have difficulties with eating and required more than intermittent cueing (as identified on the care plan). Assistance was only provided after the resident became upset. No re-assessment of the effectiveness of the strategies on the plan of care and no revisions to the level of assistance that was being provided to the resident based on their increasing difficulty with eating was made.

i) On a specified date in mid August 2015, progress notes were made by a registered staff member for resident #101 describing that they had observed the resident to be upset as they were leaving the dining room during the dinner meal. The resident

stated that they couldn't get their food to their mouth because they didn't know where their plate was. The registered staff member documented that the resident had poor vision from one of their eyes. The resident was returned to their seat and assisted with their meal and an email was sent to the Food Services Managers (FSM) to move the resident to an "assist" table so that the resident could have cueing.
ii) On a specified date in late August 2015, in the morning and after breakfast, documentation was made by one of two Associate Directors of Care that resident #101 reported to them that they required assistance to set-up, cut up their food but then could eat on their own. The ADOC made a note that a follow up would be made with the FSM to request that the resident be moved to an "assist" table for all meals and that they would discuss with nursing that a higher level of assistance would be required to ensure the resident's needs were met.
iii) On a specified date in late August 2015, documentation was made that the resident was interviewed by a social worker just after the lunch time meal and the resident reported occasionally getting assistance with their meals by a co-resident.
iv) On a specified date in late August 2015, documentation was made by a registered staff member that the resident became upset after having their supper time meal set up in front of them. Subsequently, one of two ADOCs approached the resident and asked if they needed assistance. The resident became upset and reported that they did in fact need help eating. The resident reported not being able to see out of one eye. The ADOC documented that an email was sent to the FSM that the resident needed to be moved to a different table that would better fit their changing needs.
vi) On a specified date in late August 2015, documentation made by a registered staff member revealed that one of two Food Services Managers informed them that resident #101 would be relocating to another table identified as one of two assist tables that was located in the dining room. However, the change did not occur as the resident who was going to be displaced refused to move.
vii) In mid October 2015, the Registered Dietician (RD) completed a nutritional assessment after receiving a referral from staff related to weight changes. The RD observed the resident eating lunch and documented that the resident still had trouble seeing their food after trialling a different type of plate. The date the plate was first instituted as a trial was not documented. However, the resident thought that the new plate was more helpful than the regular white plate they were previously provided. The intervention was added to the resident's care plan on the same date as the assessment. No mention was made regarding the resident's vision impairment on their one side and no mention was made regarding the need to re-locate the resident to an "assist table".

The resident was relocated to another floor in mid-December 2015 where they were

provided a seat at an "assist table". The resident was observed to be sitting at the table during the inspection on December 29 and 30, 2015. The staff were observed to be monitoring the residents at the table and resident #101 was asked if they needed assistance once the food was placed on the table. The resident was provided with the special plate and was eating independently. According to one of the two ADOCs, the resident was doing well and had not been observed as being upset since being placed at the "assist table". According to the ADOC, the resident did not typically voice their concerns unless asked.

FSM #001 (full time) and FSM #002 (part-time) and the RD were interviewed between January 4 and January 13, 2016 to determine what interventions or course of action was taken between August 18, 2015 and December 15, 2015 to ensure that the resident's needs were met duirng their meals. FSM #001 reported that the resident was seated at a table in the large activity room located near registered staff but confirmed it was not an "assist table". All three managers reported that they had not received any formal referrals from the ADOCs or the registered staff to have the resident assessed. According to all three manager's, the home's policy required that staff complete a form, either electronically or manually when an assessment was necessary. None of the manager's received a formal assessment and the two FSMs did not recall receiving any emails to have the resident evaluated. None of the managers had any notes or documentation to determine what follow up action was taken for the resident. FSM #001 was away on vacation from August 18 to early September 2015 and FSM #002 was on vacation from August 28 to mid-September 2015. The requests made by the two ADOCs and a registered staff member were all sent by email according to the progress notes made. ADOC #001 when interviewed on January 4, 2015 confirmed that they sent the email to FSM #001.

The licensee could not demonstrate what actions were taken between August 18 and December 15, 2015, including a formal re-assessment of the resident's needs related to eating assistance or a revision of the strategies on the plan of care to ensure the resident received the required level of assistance for eating. [s. 6(11)(b)]

Issued on this 26th day of January, 2016

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

Original report signed by the inspector.