Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 9, 2018	2018_551526_0008	005569-18	Resident Quality Inspection

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

THERESA MCMILLAN (526), AILEEN GRABA (682), KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): March 22, 23, 26, 28, 29, 2018, and April 3, 4, 5, and 10, 2018.

The following Critical Incident System (CIS) intakes were completed during this RQI Inspection:
Log #009749-17 related to alleged abuse;
Log #018388-17 related to alleged abuse;
Log #022663-17 related to alleged abuse;
Log #022671-17 related to transfer and positioning;
Log #001166-18 related to a fall with injury;
Log #003939-18 related to alleged abuse;
Log #006402-18 related to alleged abuse; and
Log #006403-18 related to alleged abuse.

The following onsite inquiry was completed during this RQI Inspection:
Log #007696-17 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Recreation Manager, Environmental Services Manager (ESM), Associate Director of Care/Staff Educator, Associate Director of Care, Registered Dietitian, Behavioural Supports Ontario (BSO) staff, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Recreation staff, Housekeeping staff, residents and family members.

During the course of this inspection, inspectors toured the home, observed medication administration, medication storage areas, recreation activities, reviewed clinical records, policies and procedures, training records, and investigative notes, observed the provision of resident care, resident-staff interactions, posting of required information and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

8 WN(s)
5 VPC(s)
1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug was prescribed for the resident.

According to the home's medication incident documentation system and resident #024's clinical records, they were administered resident #026's medications instead of their own on a specified day in 2017. During interview, the DOC confirmed that resident #024 had been administered medications that had not been prescribed to them. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

A) According to the home’s medication incident documentation system and resident #025's clinical records, the prescribed frequency of a medication to be administered to the resident was changed. The resident experienced a negative health outcome when this change was not implemented. During interview, the DOC stated that resident #025 was not administered medication in accordance with the directions for use as specified by the prescriber.

B) According to the home's medication incident documentation system and resident #022's clinical records, they were prescribed a medication to be administered on a given schedule. Further clinical review indicated that the medication was not administered according to the schedule. The DOC stated there was no negative outcome to the resident as a result of the error, and that the medication was not administered to residents in accordance with the directions for use as specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, 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. (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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

According to Critical Incident System (CIS) Report submitted by the home, resident #019 sustained an injury while receiving assistance with ambulation. The CIS report also identified strategies that should have been in place in relation to the resident's ambulation. Review of the written plan of care failed to identify these strategies. During an interview with staff #120 they were unclear about strategies to be used for resident #019's ambulation. The DOC confirmed that the plan of care did not set out clear direction to staff and others who provided direct care to the resident.

PLEASE NOTE: This non compliance was identified during a Critical Incident (CIS) inspection, Log #022671-17, conducted concurrently during this RQI. [s. 6. (1) (c)]

2. The licensee has failed to ensure, when a resident was reassessed and the plan of care reviewed and revised, if the plan of care was being revised because care set out in the plan had not been effective, that different approaches had been considered in the revision of the resident #003's plan of care in relation to falls prevention strategies.

Resident #003 had a number of falls of a similar nature over a specified time period. While their plan of care identified initial strategies to address their risk for falls, these strategies did not address the underlying circumstances that contributed to their falls. The PT stated that trying additional falls prevention strategies may have been beneficial in preventing resident #003's falls.

During interview, the Director of Care confirmed that resident #003's plan of care was not revised to include the consideration of strategies to prevent resident #003's falls. [s. 6. (11) (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 that, when a resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A review of a Critical Incident System (CIS) report, health records and the home’s investigative notes, identified that resident #016 exhibited abuse toward co-resident #017 on a specified day in 2017. This was confirmed during interview with the Director of Care (DOC) and Recreation staff #130. Strategies that were put in place to protect residents from abuse by resident #016 were stated in their plan of care.

According to a later Critical Incident Submission (CIS), health records, the home’s investigative notes, and interview with Personal Support Worker (PSW) #131, resident #016 was observed to abuse resident #018. During interview, the Director of Care (DOC) confirmed that resident #016 had a previous incident involving abuse of another resident, and that strategies that were put in place failed to ensure that resident #018 was protected from abuse by resident #016.

According to the Behavioural Supports Ontario (BSO) staff #129 and RPNs #108 and #109, residents continued to be at risk of abuse by resident #106. However, strategies to prevent abuse could not be found upon review of resident #016's most recent plan of care. Personal Support Workers (PSWs) #124, #125, and #126, who provided direct care to resident #016 were unable to identify strategies that were in place to mitigate the risk of abuse by resident #016 toward co-residents besides redirecting resident #016 after observing abusive incidents.

The DOC confirmed that resident #018 was not protected from abuse by resident #016, and the plan of care did not identify this risk or strategies to mitigate the risk of abuse toward co-residents.

PLEASE NOTE: This non-compliance was identified during Critical Incident (CIS) inspections #0183388-17 and #022663-17, conducted concurrently during this RQI. [s. 19. (1)]

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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. In accordance with section 221. (1) of O. Reg 79/10, the licensee has failed to ensure that staff who applied personal assistance services devices (PASDs) or monitored residents with PASDs, received training in the application, use and potential dangers of the PASD, and that this training be received annually in accordance with section 221. (2) of O. Reg. 79/10.

Review of the home's training records identified that direct care staff had not received 2017 annual training regarding the application, use and potential dangers of PASDs. During interviews, Registered Practical Nurses (RPNs) #100 and #108 stated that the home's physiotherapist (PT) would conduct all assessments of residents needing PASDs and would obtain consents. RPN #108 stated not knowing that a PASD could limit a resident's freedom of movement. During interview, the Associate Director of Care/Staff Educator (ADOC) #113 and the PT stated that if a resident required a PASD such as a tilt chair, the PT would provide training only to the staff available at the time of the initial PASD application. The ADOC confirmed that not all staff would receive this training since it was only provided at the time of initial application and that no direct care staff had received annual PASD training in the application, use and potential dangers of the PASD. [s. 76. (7) 6.]

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 all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations to include, for staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs, to be implemented voluntarily.

WN #5: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During six observations, three resident bathrooms that were each used by four residents, were observed to have lingering offensive odours. Black dried debris was noted around the base of the toilets and dried yellow/brown liquid spots were observed on the floors. During interview the housekeeper and Personal Support Workers #102 and #118 stated that these bathrooms had urine odours and that identified residents would urinate on the floors in the process of self-toileting. The housekeeper stated that they had been trying to manage the odours on their own. The housekeeper and PSWs stated that they had not notified the Environmental Services Manager (ESM) about the lingering offensive odours in these bathrooms.

During interview, the ESM described the home's process for managing lingering offensive odours that included being informed by staff if there was a problem. They stated that staff had not implemented the home’s procedures for lingering offensive odours in two of the three identified bathrooms since they had not reported the odours to the ESM either in person or through the home’s electronic maintenance reporting system. [s. 87. (2) (d)]

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 as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a personal assistance services device (PASD) described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Resident #009 was observed with a PASD that limited their freedom of movement. During interview, Personal Support Worker (PSW) #106 stated that they applied the

PASD upon resident #009's request and according to their preference.

During interview, the physiotherapist (PT) stated that they assessed the resident for the need for the PASD. Review of the document the home referred to as resident #009's care plan identified the reason for the PASD but did not direct staff in relation to the specifics of PASD's use and application. This was confirmed during interview with the PT, who stated that the plan of care normally included directions for direct care staff on how and when to apply the PASD. [s. 33. (3)]

2. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or had not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD had been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

A) During the course of this inspection, resident #009 was observed with a PASD applied that limited their freedom of movement. The PT stated that they assessed the resident for the use of a PASD. However, a review of health records failed to identify documented evidence of this assessment that outlined if alternatives to the use of a PASD had been considered and tried where appropriate, if the use of the PASD was reasonable in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. In addition, this review failed to identify the approval of the PASD by the PT, the resident's consent, or the consent of their substitute decision-maker to the use of a PASD that limited resident #009's freedom of movement; this was confirmed during interview with the PT.

During interview the DOC stated that the use of the PASD that limited resident #009’s freedom of movement should have been included in their plan of care, and evidence of an assessment, approval and consent for the PASD was not found in their health records. [s. 33. (4)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and was assessed by a registered dietitian who was a member of the staff of the home.

i) Resident #004's plan of care identified them as being at risk for altered skin integrity and they were observed to have areas of altered skin integrity during the course of this inspection. Review of their health record failed to identify assessments for all of these areas using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. This was confirmed during interview with Registered Practical Nurse (RPN) #100.

ii) Health records also identified that resident #004 had not been assessed by a Registered Dietitian (RD) for new areas of altered skin integrity. During interview, RPN #100 stated that since resident #004 had already been assessed by the RD in relation to other areas of altered skin integrity, it was not necessary to submit another RD referral. During interview, the RD stated that they wouldn’t know if a resident had a new area of altered skin integrity if they didn’t receive a referral.

During interview, the Associate Director of Care/Staff Educator (ADOC) #113 stated that all residents with new areas of altered skin integrity should receive a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and should have been referred to the RD so that the resident can receive a dietary assessment. [s. 50. (2) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written strategies to meet the needs of residents with responsive behaviours included techniques and interventions to prevent, minimize, or respond to the responsive behaviours.

According to health records and Critical Incident System reports, resident #016 exhibited responsive behaviours towards staff and co-residents. The document the home referred to as resident #016's care plan was updated after an initial incident. While the written strategies addressed what to do when the resident exhibited the behaviours, they did not include strategies designed to prevent or mitigate the risk of behaviours toward co-residents; this was confirmed by the DOC during interview. After another confirmed incident in 2017 involving resident #016's behaviours toward resident #018, written strategies to specifically address and prevent these behaviours were included in resident #016's plan of care.

During interview, Behavioural Supports Ontario (BSO) staff #129, DOC and RPNs #108 and #109 reported that a risk for the resident #016's behaviours continued to be present, that the risk should be included in the resident's written plan of care, and strategies that worked should be implemented to address this potential risk. However, during health record review, BSO notes could not be found that included the current strategies that direct care staff should implement to prevent resident #016's responsive behaviours and this was confirmed by BSO staff. Further review of resident #016's current written plan of care failed to identify the potential risk of inappropriate behaviours toward co-residents;

this was confirmed during interviews by Registered Practical Nurses (RPN) #108 and #109 who stated that since the behaviours had decreased more recently, the resident's risk and associated strategies had been removed.

During interview on April 10, 2018, Personal Support Workers (PSWs) #124, #125, and #126, who provided direct care to resident #016 said that they were not aware of the nature of incidents that initially occurred in relation to resident #016's behaviours. While these staff reported that they had not seen resident #016 exhibit these behaviours, they were unable to identify strategies that were in place to mitigate the risk of similar behaviours by resident #016 toward co-residents besides redirecting resident #016 after observing the behaviours.

The DOC confirmed that a potential risk for resident #016 to exhibit responsive behaviours toward co-residents may still exist and that current written strategies did not include techniques to prevent or mitigate the risk of resident #016's behaviours toward co-residents and that these should be included in resident #016's plan of care.

PLEASE NOTE: This non-compliance was identified during a Critical Incident (CIS) inspections Log #018388-17 and #022663-17, conducted concurrently during this RQI. [s. 53. (1) 2.]

Issued on this 5th day of June, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : THERESA MCMILLAN (526), AILEEN GRABA (682), KELLY CHUCKRY (611)

Inspection No. / No de l'inspection : 2018_551526_0008

Log No. / No de registre : 005569-18

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 9, 2018

Licensee / Titulaire de permis : Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4

LTC Home / Foyer de SLD : Garden City Manor
168 Scott Street, St. Catharines, ON, L2N-1H2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Lisa Phelps

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To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131(2) of Ontario Regulation 79/10.

Specifically the licensee must ensure that resident #022, and all other residents, are administered drugs in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use as specified by the prescriber.

A) According to the home's medication incident documentation system and resident #025's clinical records, the prescribed frequency of a medication to be administered to the resident was changed. The resident experienced a negative health outcome when this change was not implemented. During interview, the DOC stated that resident #025 was not administered medication in accordance with the directions for use as specified by the prescriber.

B) According to the home's medication incident documentation system and resident #022's clinical records, they were prescribed a medication to be administered on a given schedule. Further clinical review indicated that the medication was not administered according to the schedule. The DOC stated there was no negative outcome to the resident as a result of the error, and that the medication was not administered to residents in accordance with the directions for use as specified by the prescriber. [s. 131. (2)]

The severity of this issue was a level 3 as there was actual harm/risk to the resident. The scope was level 2 as it involved two of three residents. Compliance history was a level 2 as there were one or more unrelated non-compliance in the last 36 months. (682)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 15, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Theresa McMillan

Service Area Office / Bureau régional de services : Hamilton Service Area Office