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

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
Jun 21, 2018	2018_555506_0017	021264-17, 011853-18	Critical Incident System

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

LESLEY EDWARDS (506)

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): June 6, 7, 8 and 11, 2018.

Critical Incident Inspection:

021264-17 - related to responsive behaviours
011853-18 - related to falls prevention, plan of care and responsive behaviours

This inspection was conducted, in part, concurrently with Complaint Inspection, report number 2018_555506_0018, for log number 011584-18 and findings of non compliance for Ontario Regulation 79/10 section 6 (7) will be issued on that report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), registered nurses (RNs), registered practical nurses (RPN's), personal support workers (PSW's), Social Worker and residents.

During the course of the inspection, the inspector toured the home, observed the provision of care, reviewed clinical records, investigation notes, policies and procedures and conducted interviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O. Reg 79/10, s. 30(1) the licensee was required to have an organized program for each of the interdisciplinary programs under section 48 of this regulation, which included a fall prevention and management program, and was required to have relevant policies, procedures and protocols for the program.

Specifically, staff did not comply with the licensee's policy regarding "Head Injury Routine" last revised in March 2018, which was part of the licensee's falls prevention and management program.

This procedure identified "the nurse will notify the Physician if there is a sudden change in vital signs and or neurological assessment, or if the resident has any of the following symptoms: if the resident becomes nauseated and or vomits."

i. Clinical record review confirmed resident #005 sustained falls on an identified date in 2018. The registered staff had initiated head injury routine checks It was documented by RPN #114, as part of the head injury routine on an identified date in 2018, that the resident had a change in condition. The resident's physician was not notified that the resident's condition changed until the next shift arrived. On an identified date in June 2018, the DOC confirmed that the registered staff did not follow the home's policy and procedure regarding head injury routine as they did not notify the physician when the resident's condition changed. [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 that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol, or procedure, the licensee is required to ensure that the policy, protocol or procedure is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

According to a Critical Incident report that was submitted to the Director on an identified date in 2018, resident #005 sustained two falls on an identified date in 2018. RPN #112 assessed the resident and noticed a change in the resident's status and asked RN #104 to assess the resident. Interview with the RN on an identified date in 2018, confirmed they did complete an assessment of the resident and their assessment findings were not suggestive of a change in condition. Clinical record review and the RN confirmed they did not document their assessment findings in the clinical record. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the residents responses to interventions are documented, to be implemented voluntarily.

Issued on this 21st day of June, 2018

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

Original report signed by the inspector.