Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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_0018	011584-18	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): June 6, 7, 8 and 11, 2018

Complaint Inspection

011584-18- related to medications, nutrition and hydration, responsive behaviours and plan of care.

This inspection was conducted, in part, concurrently with Critical Incident Inspection, report number 2018_555506_0017, for log numbers 021264-17 and 011853-18 and findings of non compliance for Ontario Regulation 79/10 sections 6 (7) will be issued on this report

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Dietitian (RD), Behavioural Support Ontario staff (BSO), Seniors Mental Health Outreach Case Manager, Recreation Manager, registered staff, Personal Support Workers (PSW), agency PSW and residents.

During the course of the inspection, the inspector: toured the home, observed the provision of care such as meal service, medication passes, reviewed clinical records, policies and procedures, conductive interviews.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Medication
Nutrition and Hydration
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the residents as specified in the plan.

i. On an identified date in June 2017, resident #005 sustained an unwitnessed fall when the PSW left the room, the resident got up and fell. Clinical record review confirms that the resident was not to be left unsupervised. The DOC confirmed that the plan of care was not followed as the resident was left unattended and sustained a fall.
The above noted non-compliance was identified during CIS inspection log #011853-18/ CIS #2364-000021-18.

ii. On an identified date in August 2017, Critical Incident System (CIS) report #2364-000027-17, was submitted to the Director. According to the report, resident #001 sustained an injury and the resident had a prior incident in January of 2016, where they also sustained an injury. The home put a care plan in place to ensure that staff to check and remove items from their room. The DOC confirmed that the plan of care was not followed as the resident had access to an item on an identified date in August 2017.
The above noted non-compliance was identified during CIS inspection log #021264-17/ CIS #2364- 000027-17.

iii. On an identified date in June 2018, the Long Term Care Homes (LTCH) Inspector observed resident #002 during their meal. Resident #002's plan of care confirmed that the resident had an intervention in place. During the meal service on the identified date the intervention did not take place. Interview with the Dietitian on an identified date in June 2018, confirmed the resident was still to have this intervention in place at meal times and confirmed that the staff were not following the resident's plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

Resident #002's Medication Administration Record had a nursing measure that directed staff to perform a task. A review of the clinical record shows that the resident had been consistently refusing care not only on the identified shift but on another shift as well. Interview with the DOC on an identified date in June 2018, confirmed that the plan of care was not reviewed or revised to see if the above nursing measure would be effective in resident receiving care [s. 6. (10) (c)]

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 planned care for residents is provided as specified in their plan of care and to ensure that if the residents plan of care is not effective that it is reviewed and revised, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours.

i. Resident #002 has been refusing an intervention consistently. Review of the clinical record confirmed the resident refused the intervention during the months of March, April and May 2018. The written plan of care for resident #002 did not include a responsive behaviour focus or any interventions to prevent the resident from refusing an intervention. Interview with the DOC on an identified date in June 2018, confirmed the plan of care did not include care needs based on the assessment needs of the resident. [s. 26. (3) 5.]

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.