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 prévue 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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 19, 2019	2019_569508_0012	010565-18, 011655-18, 015244-18, 017425-18, 003244-19, 004281-19	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

ROSEANNE WESTERN (508)

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): February 27, 28, March 1 and 4, 2019.

During the course of the inspection, the inspector toured the facility, observed the provision of care, reviewed resident clinical records, relevant policies and procedures and staff training records.

PLEASE NOTE: This Critical Incident inspection was conducted concurrently with Follow Up inspection #2019_569508_0011.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Staff Educator, registered staff, Personal Support Workers (PSW)s and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

A review of Critical Incident (CI) Submission report #2364-000011-19, indicated that resident #006 was a risk for falls and also had identified responsive behaviours.

On an identified date in 2019, the resident was complaining of pain and it was observed by registered staff that the resident had swelling on an identified area of their body. An x-ray was ordered as an injury was suspected. The resident was transferred to hospital for further assessment where an injury was confirmed; however, after an investigation it could not be confirmed how the resident was injured.

The resident returned to the home with a specific intervention in place and pain medication was ordered to manage the resident's pain. The resident's pain medication was also increased to include breakthrough pain medication (BTP) as required, in addition to the regularly scheduled pain medication.

During this inspection, it was identified that the resident had received the additional BTP medication to manage their pain over an identified period of time. The Long Term Care Homes (LTCH) Inspector requested a copy of the resident's most recent pain assessment. Registered staff #101 indicated that the staff were monitoring the effectiveness of the resident's pain medication; however, a pain assessment using a clinically appropriate assessment instrument could not be located.

The home had implemented a 72 hour pain monitoring guideline form on an identified date; however, a pain assessment using a clinically appropriate assessment instrument had not been completed when the resident had exhibited signs and symptoms of pain, required BTP medication and had a confirmed injury.

It was confirmed by the Executive Director (ED) that a pain assessment using a clinically appropriate assessment instrument should have been completed for resident #006. [s. 52. (2)]

Issued on this 27th day of March, 2019

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

Original report signed by the inspector.