Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 13, 2020	2020_669642_0006	022956-19, 023827-19, 002645-20	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

AMY GEAUVREAU (642), STEVEN NACCARATO (744)

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 24-28, 2020.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

-Three logs: related to residents' falls, which caused injuries.

A Complaint Inspection #2020_669642_0005, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (Administrator), Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Staff Educator, Physiotherapist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed resident health care records, relevant training, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention

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

Findings/Faits saillants :

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

A Critical Incident (CI) report was submitted to the Director, related to resident #003 having a fall, while being provided specific care, by Personal Support Worker (PSW) #115. Resident #003 received injuries, as a result of the fall. The CI report identified resident #003 required an identified number of staff members to provide specific personal care.

Inspector #642 reviewed resident #003's care plan, which was in effect at the time of the fall, and under a specific "Focus," [for personal care]," it stated in the interventions that resident #003, required a specific number of staff members for assistance.

Inspector #642 reviewed a progress note written under the, "Risk Management" on Point Click Care (PCC), and identified Registered Practical Nurse (RPN) #116 had interviewed PSW #115, who had been providing specific care to resident #003, on the specific shift. PSW #115 described their actions when resident #003 had fallen.

The Inspector interviewed Registered Nurse (RN) #114, and Assistant Director of Care (ADOC) #113 who had interviewed PSW #115 about the incident. PSW #115 indicated they had not been providing the care resident #003 required, on that specific shift.

The Inspector interviewed PSW #117, RPN #103, and RN #118, who stated that all staff were required to provide resident care as specified in the care plan.

The Inspector reviewed the policy titled, "Role Profile-Personal Support Worker," which identified the key responsibilities for the PSWs that stated they are to adhere to the plan of care as determined by the supervisor.

In an interview with the Director of Care (DOC), they stated PSW #115 had not been providing the care resident #003 required, on a specific shift, when they fell. Inspector #642 reviewed the care plan in effect at the time of the fall with the DOC and they acknowledged that under a specific, "Focus" for resident #003, it did state that resident #003 required different care than what PSW #115 provided [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 18th day of March, 2020

[redacted]

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

Original report signed by the inspector.