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 2, 2021	2021_866585_0001	017989-20, 019723-20, 021040-20, 023420-20, 000528-21	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 Catherines ON L2N 1H2

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

LEAH CURLE (585)

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 3, 4, 10, 11, 17, 18, 19, 23 and 24, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #017989-20, CIS #2364-000026-20 related to transfers
Log #019723-20, CIS #2364-000031-20 related to injury of unknown cause
Log #021040-20, CIS #2364-000036-20 related to injury of unknown cause
Log #000011-20, CIS #2364-000042-20 related to a respiratory outbreak
Log #000528-21, CIS #2364-000001-21 related to falls

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC)/Staff Educator, Infection Prevention and Control (IPAC) Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), the Physiotherapist (PT), Personal Support Workers (PSWs), the receptionist, housekeeping staff, recreation staff, and a 3rd party security staff.

During the course of the inspection, the inspector(s) observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for a resident that set out their planned care for falls prevention and management.

In January 2021, a resident sustained an injury from a fall. A Physiotherapy Assessment was completed and listed a new care intervention for the resident. The written plan of care was reviewed and did not include the intervention, as confirmed by the Physiotherapist (PT).

During the inspection, the resident was observed with several fall interventions in place; however, their written plan of care did not include all of the interventions. The PT confirmed the interventions were part of the planned care for the resident but not all had been documented in the written plan of care.

Failure to include the all interventions in the written plan of care increased risk of pain or injury to the resident.

Sources: Physiotherapy Assessment, resident care plan and clinical record, resident observation, interview with the PT and other staff. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident for falls interventions and transfers.

A resident’s care plan, which was part of their written plan of care, noted instructions related to fall interventions and the level of assistance they required for transfers.

Instruction in the resident's care plan for falls intervention was unclear, which was confirmed by the PT.

Instructions for transfers in the care plan differed from written direction in the resident’s room, as confirmed by a Registered Practical Nurse (RPN).

Failure to ensure the written plan of care provided clear direction increased risk to the resident as staff relied on plan to inform them of the resident's care needs.

Sources: resident written plan of care, resident observation, interview with the PT and an RPN. [s. 6. (1) (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 and ensure that there is a written plan of care for each resident that sets out the planned care for the resident and clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that a staff member used safe techniques when attempting to assist a resident with a transfer.

A Critical Incident System (CIS) report and investigation records identified an incident in 2020 when a staff member failed to use safe transfer techniques when assisting a resident. The staff confirmed they failed to use safe transfer techniques when they attempted to assist the resident, and the incident resulted in injury to the resident.

Sources: CIS report #2364-000026-20, investigative notes, resident clinical records, interviews with staff. [s. 36.]

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 and ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program in relation to hand hygiene during meals and snacks.

The home's policy, "Preventing the Transmission of Infection", noted the home followed routine practices and additional precautions in accordance with current Canadian and provincial/regional standards, which included:

- Public Health Ontario, Provincial Infectious Diseases Advisory Committee: Best Practices for Hand Hygiene in All Health Care Settings. 4th Edition, April 2014.
- Just Clean Your Hands (JCYH) program.

The JCYH program and implementation guide directs to clean residents' hands before and after meals or snacks and for staff to perform hand hygiene after exposure to body fluid exposure risk.

During the inspection, the following observations were made:

During an afternoon snack pass, a PSW failed to clean a resident's hands prior to serving them a snack. The Assistant Director of Care (ADOC) confirmed staff should have assisted the resident with hand hygiene prior to offering the nourishment.

During a lunch meal service, a PSW failed to perform hand hygiene after touching a soiled beverage cup. The PSW continued to serve residents' lunch, and confirmed they should have cleaned their hands but forgot.

Not performing hand hygiene or offering hand hygiene to residents when indicated put residents at risk as the entire home was on contact and droplet precaution due to a COVID-19 respiratory outbreak.

Sources: The home's policy, "Preventing the Transmission of Infection - IPC2-P10", dated March 2020, snack observation, lunch observation, interview with the ADOC and a PSW. [s. 229. (4)]

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 and ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 22nd day of March, 2021

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

Original report signed by the inspector.