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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 20, 2023	
Inspection Number: 2023-1067-0004	
Inspection Type: • Complaint • Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Garden City Manor, St Catherines	
Lead Inspector Jennifer Allen (706480)	**Inspector Digital Signature**

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 25-26, 29-31, and June 1-2, 2023.

The following intake(s) were inspected:

- Intake: #00006501 - Critical Incident # 2364-000008-22 relating to resident with an injury.
- Intake: #00087653 - Complaint with concerns regarding resident plan of care, abuse and neglect, foot care and transferring and positioning techniques.
- Intake: #00087660 - Critical Incident # 2364-000051-23 relating to Improper/Incompetent treatment of a resident.

The following **Inspection Protocols** were used during this inspection:

- Skin and Wound Prevention and Management
- Medication Management
- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Air Temperature

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3).

Rationale and Summary
Review of the home's Resident Home Area Daily Temperature Log between May 16 – 24, 2023, identified missing air temperature records in the evening on seven occasions for four designated cooling area on Orchard dining room and lounge and Terrance dining room and lounge.

Staff failure to monitor temperatures within the home placed the residents at risk of being exposed to low or high temperatures.

Sources: Resident Home Area Daily Temperature Log May 16 – 24, 2023; and interviews with the Environmental Service Manager, the Director of Care (DOC), and other staff.

[706480]

WRITTEN NOTIFICATION: Pain Monitoring

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10: s. 48 (1)(4).
The licensee has failed to ensure the registered staff completed the 72-hours pain monitoring for a resident.

In accordance with O. Reg. 79/10 s. 8(1)(b) that the licensee shall ensure their pain program includes a process to identify and manage pain.

Specifically, the licensee did not comply with the home's Pain Assessment and Management policy, which directed registered staff to complete 72-hour monitoring when a new pain was identified.

Rationale and Summary
Critical Incident Report # 2364-000008-22 reported that a resident had new symptoms and pain and was transferred to the hospital the same day, and diagnosed with a significant injury.

Progress notes stated staff alerted the registered staff that the resident was observed with symptoms

of pain during care. The registered staff assessed the area and transferred to the resident to the hospital for further assessment. The resident returned with diagnoses with significant injury.

The electronic Medication Administration Record (eMar) identified the resident's PAINAID score was above their baseline. The home's Pain Assessment and Management Policy stated after the resident was screened to be experiencing a new pain, 72-hour monitoring should be completed.

The Pain Monitoring Sheet for monitoring the resident's pain was not initiated nor was an entry in the eMAR for monitoring the pain.

Failure to monitor the resident pain may lead to prolonged pain and unsuitable interventions.

Sources: Pain Assessment and Management Policy (CARE8-O10.01, last reviewed March 31, 2023); Pain Monitoring Sheet; interviews with staff and the DOC.
[706480]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c).
The licensee has failed to ensure that a resident had a written plan of care that set out, clear directions to staff who provide direct care to the resident, specifically regarding transferring the resident.

Rationale and Summary
A resident sustained an injury to their skin integrity during a transfer from bed to their wheelchair.

The resident's plan of care stated they were a medium risk for falls and required extensive assistance for transferring and toileting with two staff assist.

A staff member stated when they approached the resident in bed for toileting purposes, they observed the transfer logo for toileting posted at the head of resident's bed and continued to proceed with the transfer as per the toileting transfer logo of one staff. The most recent SALT assessment indicated one

staff assist for toileting and two staff assist for all other transfers.

Failure to provide clear direction to staff regarding the transferring of a resident resulted in harm and risk of harm for the resident.

Sources: resident #001's clinical records, eMARs, interviews with staff and the DOC.
[706480]

WRITTEN NOTIFICATION: Notifying the Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
The licensee failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, immediately reported to the Director.

Rationale and Summary
The home submitted Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) regarding allegations of improper care for a resident.

A staff member stated when they transferred the resident from bed to wheelchair the resident sustained an injury. The home’s investigation notes identified that the staff member did not follow the resident’s plan of care.

The home’s Mandatory Reporting of Resident Abuse or Neglect Policy stated that incidents of improper or incompetent care should have been reported to the MLTC immediately. The home’s internal investigation file summary supported that the date of incident two days prior, and the home’s investigation concluded one day prior to submitting the report.

There was increased risk to the residents related to the allegation of improper care not being reported immediately.

Sources: CIS report; Mandatory Reporting of Resident Abuse or Neglect Policy (ADMIN-O10.01, last revised, March 31, 2023); the home’s investigation documentation; interviews with staff and the DOC.
[706480]

WRITTEN NOTIFICATION: Foot Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (1).
The licensee failed to ensure that a resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Rationale and Summary
A foot care intervention was development for a resident under the bathing focus in their plan of care, that foot care was to be completed by the registered staff.

The Ministry of Long-Term Care (MLTC) received a complaint regarding the resident's toenails being too long and very thick and not having been cut or trimmed.

The resident had a history of chronic disease. Staff members stated for residents with diagnoses that affect their feet, staff only do minimal nail care, and any nails that are too thick are referred to the foot care nurse and not touched by the staff.

The registered staff stated they referred the resident for foot care and spoke to the power of attorney (POA) for consent.

The resident consented for foot care every six weeks and was signed by the POA, but not activated and the resident never received foot care from the Foot care nurse.

Failure to complete regular foot care, including cutting of the toenails for the resident may have impacted care and comfort which could have put the resident at further risk of harm.

Sources: the resident's plan of care; interviews with the staff, the DOC and the Office Manager.
[706480]

COMPLIANCE ORDER CO #001 Transferring and Positioning

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:
1. The management team must review a) the home's Transfer and Lift policies and procedures relating to the use of transfer logos and b) any policies and procedures relating to providing clear direction to staff when more than one transfer logo is required. The management team members who complete the review must sign an attestation of said review, that includes the name of the members, date of review, material that was reviewed, any action plan developed as a result of the review and a summary of any changes.
2. The home must develop and conduct weekly audits to be completed of the transfer logos for accuracy relating to the plan of care for transferring and toileting for 4 consecutive weeks. The record of the audits must be kept for inspector review.
3. The home must re-educate all full-time and part-time PSW and registered staff relating to the home's Transfer and Lift policies and procedure and the use of the transfer logos and their responsibilities.
4. The Home must keep a record of the education, material provided, name and signature of staff receiving the education, date of education and identify any changes necessary based on these results for inspector to review.

Grounds

Non-compliance with: O. Reg. 246/22, s. 40.

The licensee failed to ensure that two staff were used for safe transferring when assisting resident #002.

Rationale and Summary

A) A staff member stated when they approached the resident in bed for toileting purposes, they observed the transfer logo for toileting posted at the head of resident's bed was for a one staff assist and continued to proceed with a one staff transfer. The staff member stated that there were two transfer logos located at the head of the bed, one for transferring and another specifically for toileting. As a result of transfer the resident, they sustained an injury.

The resident's plan of care at the time of the injury indicated that they required two persons extensive assistance for transferring from bed to wheelchair.

The Safety in Ambulating Lifting and Transferring (SALT) assessment indicated that they required a two staff assist when transferring and one staff assist for toileting.

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B) On another day, another staff member answered the call bell for the resident to go the toilet. The staff stated their partner was on break and offered the resident to transfer them alone with their help. The staff confirmed they transferred the resident from bed to wheelchair alone.

Failure to provide the correct transfer assistance for the resident increased their risk of potential injury.

Sources: resident's clinical record; SALT assessment; interviews with staff and the DOC.
[706480]

This order must be complied with by July 24, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.