Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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: December 15, 2023

Inspection Number: 2023-1067-0007

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Garden City Manor, St Catherines

Lead Inspector	**Inspector Digital Signature**
Stephany Kulis (000766)	Stephany Kulis Digitally signed by Stephany Kulis Date: 2023.12.20 16:13:08 -05'00'

Additional Inspector(s)
Jonathan Conti (740882)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 1-3, 6-10, 14-17, 2023.
The following intake(s) were inspected:
· Intake: #00019824 - Critical Incident (CI) 2364-000014-23 - Late Reporting - Physical abuse staff to resident.
· Intake: #00085758 - CI- 2364-000035-23 - Controlled Substance missing/unaccounted-Emergency medication box
· Intake: #00090458 - CI- 2364-000065-23 - Fall of resident resulting in injury.
· Intake: #00091353 - CI- 2364-000069-23 - Fall of resident resulting in injury
· Intake: #00094106 – CI- 2364-000077-23 - Fall of resident resulting in

injury.
· Intake: #00096707 - CI- 2364-000084-23 - Fall of resident resulting in injury.
· Intake: #00098958 - CI- 2364-000089-23 - Fall of resident resulting in injury.
· Intake: #00099188 - Complainant re. resident with concerns regarding housekeeping, and plan of care related to skin and wound care.
· Intake: #00099570 - Complainant re. resident with concerns regarding plan of care related to skin and wound care.
· Intake: #00099892 - CI- 2364-000091-23 - Fracture of resident of unknown etiology.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Staff and others to be kept aware

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)

Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure staff were aware of a resident's dietary requirements.

Rationale and Summary
On a day in November, the resident received a restricted food item. A student stated they were going around the home area asking if residents would like a beverage but they were not aware of the contents of the resident's plan of care and did not know if they had dietary restrictions. The student confirmed the beverage contained a restricted food item.

As a result, ingesting the restricted food item may cause discomfort to the resident.

Sources: Interview with PSW and Student; a resident's plan of care, MD orders; RD assessments
[000766]

WRITTEN NOTIFICATION: Plan of Care- Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of care was documented as set out in the plan of care for a resident.

Rationale and Summary
In the resident's plan of care, the resident required assistance for all toileting needs and had a toileting schedule. The required toileting schedule to keep the resident clean and dry was to offer toileting at different times of the day and as needed.

The resident's survey report for November 2023 related to toileting plan was not documented at the specified times during that period.

A PSW acknowledged that task documentation for the resident was not documented during those times. A Registered Nurse (RN) and the Director of Care (DOC) confirmed the expectation of a PSW staff was to document when care provided was completed as per plan of care in the tasks section, and acknowledged that this was not completed.

The lack of provision of care documentation as required by the resident's plan of care posed a risk that resident care may not have been provided.

Sources: resident clinical record including care plan, documentation survey report November 2023; interviews with DOC, RN, and PSW.
[740882]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure immediate reporting to the Director of the alleged abuse of a resident that resulted in a risk of harm.

Rationale and Summary
A Critical Incident (CI) report was submitted one day later in relation to an incident of alleged abuse of the resident. A RN was made aware of the alleged incident when it was reported to them during the same evening of the incident. A RN communicated the report of alleged abuse to the DOC the same evening.

The DOC acknowledged that the incident was not immediately reported to the Director through the after hours pager when they were first made aware of the incident.

Sources: Interviews with DOC and RN; Critical Incident Report 2364-000014-23; resident progress notes; internal investigation notes.
[740882]

WRITTEN NOTIFICATION: Maintenance services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented

to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee failed to ensure the implementation of procedures to ensure that a device was kept in good repair.

Rationale and summary
A resident was assessed a high falls risk due to their history of several falls. As a falls management intervention, the resident required the use of a device when they were in bed.

The resident was observed to be laying in bed. The resident's device was in place, however there was a broken cord that connected the device to a battery pack.

A PSW confirmed the status of the device, it was acknowledged that the resident had previously pulled at and broken the cord. A RN acknowledged they had observed the device was not functioning due to the complete break of the cord and that it was pulled by the resident. A RN stated that a request for repair or replacement was made to the Physiotherapist (PT) that morning.

PT confirmed that they were informed by the RN that the resident's device had broken that same morning, and was required to replace the device due to it not working. The resident's device was noted to be replaced during follow-up observations that same afternoon.

As a result of the resident's device not being kept in good repair, the resident was put at an increased risk for injury from a potential fall.

Sources: Resident's clinical records, resident observations ; interviews with RN, PT, and other staff.
[740882]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
3. A missing or unaccounted for controlled substance.

The licensee has failed to ensure that the Director was informed of an incident of missing/unaccounted for controlled substances after several controlled substances were discovered to be missing.

Rationale and Summary
On a day in January 2023, a RPN and a Registered Pharmacist (Rph) completed Emergency Medication Audit and Reorder Form and noted the several controlled substances missing.

No record of a critical incident report was found for this incident. A RPN stated they did not report the incident to the Director. The DOC stated staff failed to report the missing/unaccounted for controlled substances to the Director when discovered in January 2023 during the Emergency Medication Audit.

Sources: Interview with DOC and RPN; January Emergency Medication Audit and

Reorder Form.
[000766]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the Director was informed of an incident that caused an injury to a resident for which they were taken to hospital and that resulted in a significant change in their health condition.

Rationale and Summary
A resident had a fall for which they were taken to hospital and that resulted in a significant change to their health status. No record of a critical incident report was found for this incident.

Staff interviewed confirmed the resident had a fall, and when the resident returned there was a significant change to their activities of daily living (ADLs). Prior to hospitalization, the resident was mobile with an assistive device, however on return from hospital required the need for a wheelchair.

The DOC confirmed there was a significant change to the resident after the fall with injury and required reassessment from the interdisciplinary team. The DOC acknowledged that the Director had not been informed of the incident and that no critical incident report was submitted.

Sources: resident's clinical records; interview with PSWs, RNs, RAI-Coordinator back up, and DOC; observation resident.
[740882]

WRITTEN NOTIFICATION: Emergency drug supply

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 132 (b)
Emergency drug supply
s. 132 (b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;

A. The licensee has failed to comply with ensuring staff used best practice standards to fax the Emergency Medication Replacement forms once daily.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required ensure once staff fill out the Emergency Medication Replacement Form it is to be faxed to the pharmacy once daily and a new sheet is started and must be complied with.

Specifically, staff did not comply with the "Policies and Procedures: Manual for MediSystem Serviced Homes" dated June 2022 which the procedure in the emergency binder was derived from for directions.

Rationale and Summary
On several occurrences, the Emergency Medication Replacement Forms were not faxed daily as per policy. The forms indicated the home had not received the replacement medications from pharmacy once the medications were taken from the emergency drug supply.

The DOC stated this was how the mistakes in the audits happened, the pages were supposed to be closed after faxing, and should have been faxed once daily. Failing to fax the Emergency Medication Replacement Forms as per policy resulted in discrepancies in the Emergency Box Audits because the pharmacy was unaware to replace the medication.

As a result, there was a risk in delay of treatment for residents needing to start medications immediately due to the shortage in medications in the emergency medication box.

Sources: Interview with DOC; Emergency Medication Replacement Forms; Policies and Procedures: Manual for MediSystem Serviced Homes; Emergency Medication Audit and Reorder Form.
[000766]

B. The licensee has failed to comply with ensuring a pharmacist was present to check the inventory and stock of the emergency drug supply for the month of March 2023.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure there is a pharmacist present when completing the Emergency Medication Audit and Reorder Form and must be complied with.

Specifically, staff did not comply the "Policies and Procedures: Manual for MediSystem Serviced Homes" dated June 2022 which included the requirements of a pharmacist or Quality Insurance Nurse (QIN) to complete the emergency medication audits.

Rationale and Summary
An Emergency Medication Audit and Reorder Form was completed by a RPN, there was no signature of a pharmacist on this form. A RPN stated they completed the audit with no pharmacist present. The DOC stated Emergency Medication Audit and Reorder forms are to be completed with a pharmacist in the presence of a staff member from the home.

As a result, a pharmacist not completing the Emergency Medication Audit and Reorder form may result in error in reordering medications for the emergency medication supply for the entire home.

Sources: Interviews with DOC, RPN and Rph; Policies and Procedures: Manual for MediSystem Serviced Homes.
[000766]

C. The licensee has failed to comply with ensuring two registered staff sign out medication from the emergency drug supply on the Emergency Medication Replacement Forms.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required ensure staff fill out appropriate sections on the Emergency Medication Replacement Forms including two registered staff signing out medications together and must be complied with.

Specifically, staff did not comply with the "Policies and Procedures: Manual for MediSystem Serviced Homes" dated June 2022 which the procedure in the emergency binder was derived from for proper signing out of medications.

Rationale and Summary
A controlled substance was taken out of the emergency medication box for a resident. On the form, only one registered staff had signed the medication out. The DOC stated there must always be two signatures when a medication is signed out from the emergency medication box.

As a result, safe medications practices were not used when only one registered staff signed out a controlled substance.

Sources: Interviews with DOC; Emergency Box procedure; Policies and Procedures: Manual for MediSystem Serviced Homes.
[000766]

WRITTEN NOTIFICATION: Security of drug supply

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 3.
Security of drug supply
s. 139 3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 246/22, s. 139; O. Reg. 66/23, s. 27.

The licensee has failed to ensure staff conducted monthly audits of the Daily Count Sheets of Controlled Substances.

Rationale and Summary
Two registered staff were supposed to conduct monthly audits of the Daily Count Sheets of Controlled Substances. On the audit form only January 2023 to June 2023 was filled out, the remainder of the months were blank. The home did not complete audits for the months of July 2023 to October 2023. The DOC stated after the ADOC left the home, another staff member did not take on the task and could not locate the audits.

As a result, without conducting audits of the daily count sheet the home was unable to determine if there were any discrepancies for four months and was not able to take immediate action to investigate medication errors that may resulted in harm of residents.

Sources: Daily Count Sheets of Controlled Substances Audit for July 2023, August 2023, September 2023, October 2023; Interview with DOC.
[000766]

COMPLIANCE ORDER CO #001 Plan of care

NC # Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The licensee shall provide education for all Registered Nursing staff and Personal Support Workers who work on a specific home area on the resident's plan

of care regarding their intervention of a device, including the home's processes and procedures for obtaining and implementing the intervention; and
2. Document the education, including the date(s) it was held, the staff members who attended, and the staff's signatures that they understood the education; and
3. The Licensee shall ensure that there is a process developed and implemented to ensure that resident's device is worn as per the resident's plan of care; and
4. Perform daily audits for two weeks on resident's device to ensure that it is worn and in place; and
5. Document the audits, including any identified discrepancies and actions made based on audit results; and
6. The home must keep a record of the education and audits for the LTCH inspector to review.

Grounds
A. The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
For approximately one month, the resident had a history of several documented falls. The resident was assessed by a PT as a high fall risk due to a history of multiple falls and recent return from hospital. The assessment and resident's plan of care had fall prevention and management interventions including a device to be worn daily.

The resident was observed to be laying in bed. Inspector requested for a PSW to show if the resident's device was in place. At that time, it was observed that the resident was not wearing their device. A PSW showed what the device looked like and confirmed that they were not being worn by the resident at time of observation.

A RN confirmed that the resident had in their care plan to wear the device to

prevent injury from falls. Later that same day, a follow-up observation of the resident in bed, in their room was conducted with a RN present. After a RN checked the resident, there was no device in place. A RN again acknowledged that the device that was to be worn daily and called for PSW staff to put the intervention in place.

Due to the resident's history of falls and assessed fall risk, the resident was put at an increased risk for injury when the device was not in use as required by their plan of care.

Sources: Resident clinical records; observations of resident interventions; interviews with RN, PT and other staff.
[740882]

B. The licensee has failed to ensure a resident had their follow-up bloodwork as per plan of care.

Rationale and Summary
A Medical Doctor (MD) ordered for the resident to have a 3 month follow-up. A RN stated staff failed to provide the proper notification that bloodwork was needed for the resident when order was received. A RN confirmed 3 month follow-up bloodwork was not completed as per orders and was not be in resident's plan of care.

As a result, the resident did not get bloodwork drawn as ordered which may have resulted in a delay of treatment changes for disease management.

Sources: Interview with RN; resident's clinical records.
[000766]

C. The licensee has failed to ensure staff applied a resident's therapeutic device.

Rationale and Summary
A resident has co-morbidities and has a therapeutic device to help with symptom management. One day after lunch, inspector observed the resident was not wearing therapeutic device as per plan of care. A RPN stated they were aware of the contents in the resident's plan of care to apply therapeutic device in the morning and was not applied that morning as per plan of care.

As a result, the resident was not wearing their therapeutic device consistently which would be beneficial for symptom management.

Sources: Interview with RPN; resident's clinical records and resident observations [000766]

This order must be complied with by January 12, 2024

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

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.