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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 23, 2014	2014_190159_0002	H-000942-13	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

ASHA SEHGAL (159)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 10, 13, 14, 15, 2014

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Associate Director of Care, Registered Practical Nurses, Registered Nurses, Personal Support Workers (PSWs), Cooks, Dietary Aides, Food Service Manager, Registered Dietitian and residents.

During the course of the inspection, the inspector(s) observed food production and meal service, reviewed health records, plans of care for identified residents, reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not that the home's Food and Fluid Intake Monitoring Policy (LTC-G-30) was complied with by staff. The policy stated all residents will be monitored for food and fluid intake. Intake will be documented and calculated either by using paper intake monitoring or Point of Care(POC).
Resident #0001 did not have intake consistently recorded by staff. The Point of Care food and fluid intake monitoring records were found incomplete. Several entries were missing in the month of October 2013 and November 2013. Examples: 32 meals, snacks and fluid intake entries were not recorded in the month of October 2013. In the month of November 2013, 9 meals, snacks and fluid intake entries were not recorded.

Resident #0002 did not have intake consistently recorded by staff. The Point of Care food and fluid intake monitoring records were incomplete. Examples: 13 meals, snacks and fluid intake entries were not recorded in the month of September 2013 and 23 meals, snacks and fluid intake entries were not recorded in the month of October 2013. [s. 8. (1)]

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 all plans, policies, protocols, procedures and strategies are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee had not ensured that an action was taken with respect to resident #0001, resident #0002 and resident #0003 under the hydration program, including assessments, reassessments, interventions and residents' responses to interventions documented.
Resident #0001's Point of Care (POC) daily fluid intake record indicated the resident had consumed most days less than the estimated fluid requirements. The daily estimated fluid requirements documented in the plan of care was 1665 mls/day, however, the intake records indicated resident had consumed 7/16 days (November and December 2013) less than the estimated requirements.
The plan of care had identified resident #0001 at high risk for abnormal bowel movements due to reduced fluid intake. The Registered staff interviewed stated resident had poor fluid intake, and confirmed resident's hydration needs were not reassessed.

The Point of Care(POC) food and fluid intake records for resident #0002 were reviewed and identified resident's fluid intake was less than the estimated hydration requirements. The Point of Care daily fluid intake records identified resident's fluid intake was less than 200mls most days during the month of October 2013. A referral to the Registered Dietitian was not initiated when resident's fluid intake was less than the estimated hydration requirements for several days during the month of October 2013. Registered Dietitian interviewed confirmed that the resident's hydration status was not reassessed and the nutrition focus for hydration did not outline care plan interventions for poor fluid intake.

The food and fluid intake tracking document Point of Care for resident #0003 was reviewed. The plan of care dated December 2013 had identified resident's estimated fluid requirements. However, the fluid intake record for December 2013 and January 2014, indicated the resident had consumed 7/15 days less than 50 % of the estimated fluid requirements. There was no documentation to support that a referral to the Registered Dietitian was initiated to assess the resident's hydration status and intervention to maintain adequate hydration. The Registered Dietitian confirmed that the resident's hydration needs were not reassessed and interventions were not care planned. [s. 30. (2)]

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 action is taken with respect to a resident under a program, including assessment, reassessments, interventions, and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 18th day of February, 2014

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

Asha Sehgal