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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 29, 2015	2015_248214_0002	H-001314-14	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

CATHY FEDIASH (214)

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 7, 8, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care(DOC); Associate Director of Care(ADOC); Environmental Services Manager (ESM). The inspector also reviewed relevant clinical records, policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Safe and Secure Home

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	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 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

i) A review of clinical records for resident #100 indicated that on an identified date in 2014, the resident had eloped from the home and was found outside in the home's parking lot. A one second power cut to the home caused the magnetic locks on the locked doors to release, allowing the resident to gain access to the outside of the home. A review of the resident's written plan of care indicated that interventions of 30 minute safety checks were to be implemented. A review of the Wanderer's Checklist for this resident over an identified period of eight days, indicated that 30 minute safety checks were not completed on 32 occasions.

ii) A review of clinical records for resident #200 indicated that on an identified date in 2014, the resident had eloped from the home and was found outside in the home's parking lot. A one second power cut to the home caused the magnetic locks on the locked doors to release, allowing the resident to gain access to the outside of the home. A review of the resident's written plan of care indicated that interventions of 30 minute safety checks were to be implemented. A review of the Wanderer's Checklist for this resident over an identified period of eight days, indicated that 30 minute safety checks had not been implemented.

iii) A review of clinical records for resident #300 indicated that on an identified date in 2014, the resident had eloped from the home and was found outside in the home's parking lot. A one second power cut to the home caused the magnetic locks on the

locked doors to release, allowing the resident to gain access to the outside of the home. A review of the resident's written plan of care indicated that interventions of 30 minute safety checks were to be implemented. A review of the Wanderer's Checklist for this resident for an identified period of seven days, indicated that 30 minute safety checks were not completed on two occasions.

An interview with the DOC confirmed that the care set out in the plan of care was not provided to the resident's as specified in their plan. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A review of resident #100's clinical records indicated that they were diagnosed with urinary tract infections on three identified dates in 2014. A review of the resident's written plan of care indicated that these infections had not been identified and no interventions were in place to manage these infections nor minimize or prevent further re-occurrences. An interview with the DOC confirmed that the resident's plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

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 and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #2: 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 failed to ensure that any plan, policy protocol, procedure, strategy or system was complied with.

A review of the home's policy titled, Wandering and Elopement Protocol (LTC-K-50 and dated August 2012) indicated under National Operating Procedure that the following would be completed:

i) Residents will be screened prior to or at admission to determine their risk of wandering, exit seeking and/or elopement.

An interview with the DOC confirmed that resident #100, #200 and #300 were not screened prior to or at admission to determine their risk of wandering, exit seeking and/or elopement.

ii) All occurrences of elopement will be investigated.

An interview with the DOC confirmed that a Resident Incident Internal Report had been completed for residents #100, #200 and #300 which indicated the elopement had occurred as a result of the magnetic locks releasing due to a power outage, however an investigation into the elopement of these resident's identifying the reason(s) for the power outage and how the resident's eloped from the home, was not completed. [s. 8. (1) (b)]

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 any plan, policy protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules were complied with: All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.

A review of clinical records for resident #100, #200 and #300 indicated that on an identified date in 2014, all three residents had eloped from the home and were found outside in the home's parking lot. Clinical records and an interview with the DOC indicated that the residents were not to be outside alone and that they had been gone for less than three hours and no injuries were sustained. A review of a form titled, Resident Incident Internal Report that was completed for resident #200 indicated that there was a one second power cut to the home which caused the magnetic locks on the locked doors to release, allowing these residents to gain access to the outside of the home.

An interview with the ESM indicated that the home is not currently served by a generator and that staff in the home are to monitor the doors leading outside, when the magnetic locks on the doors become released. The ESM confirmed that the doors leading to the outside were not monitored by staff when the magnetic locks released due to a power outage. [s. 9. (1) 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 to ensure that the following rules are complied with: All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans, to be implemented voluntarily.

Issued on this 2nd day of February, 2015

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

Original report signed by the inspector.