Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Aug 7, 2019	2019_560632_0017	007424-19	Complaint

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. Catharines ON L2N 1H2

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

YULIYA FEDOTOVA (632)

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): July 4, 5, 8, 10, 11, 2019.

The following Complaint inspection was completed:
log #007424-19 - related to prevention of abuse and neglect, continence care and bowel management, nutrition and hydration and sufficient staffing.

Critical Incident System (CIS) inspection #2019_560632_0016 was conducted concurrently with this inspection:
log #007038-19 - related to prevention of abuse and neglect, continence care and bowel management, nutrition and hydration and sufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Receptionist, Infection Control Nurse/Admission, Resident Assessment Instrument (RAI) Co-ordinator, Physician, Resident Services Co-ordinator/Social Service Worker, personal support workers (PSWs), registered nurses (RNs), registered practical nurses (RPNs), residents and their families.

During the course of the inspection, the inspector observed the provision of care and services, reviewed documentation, including clinical health records, policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

Findings/Faits saillants :

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

Complaint log #007424-19 (IL-65704-HA/IL-66002-HA) submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in April, 2019, and Critical Incident System (CIS) log #007038-19 (AH IL-65540-AH/CI 2364-000020-19) submitted to the MOHLTC on an identified date in March, 2019, identified concerns related to the neglect of resident #001.

Progress notes review indicated that on an identified date in March, 2019, resident #001 was in a specified location.

On an identified date in July, 2019, PSW #105, indicated that on identified shift on an identified date in March, 2019, resident #001 performed specified activity and was not provided identified assistance. Resident #001 performed specified activity on specified shift on an identified date in March, 2019, and identified assistance was not provided.

Review of the specified Assessment and Plan of Care indicated that resident #001 had specified condition and required identified assistance. Progress note review indicted that resident #001 required specified assistance with all Activities of Daily Living (ADLs).

On an identified date in July, 2019, the DOC indicated that the home expectations were that PSWs checked residents twice a shift if identified assistance was required.

The home failed to ensure that the care set out in the care plan was provided to resident #001 as specified in the plan. [s. 24. (6)]

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 ensuring that the care set out in the care plan is provided to the resident as specified in the plan, 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 failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. Complaint log #007424-19 (IL-65704-HA/IL-66002-HA) submitted to the MOHLTC on an identified date in April, 2019, and CIS log #007038-19 (AH IL-65540-AH/CI 2364-000020-19) submitted to the MOHLTC on an identified date in March, 2019, identified concerns related to the neglect of resident #001.

Review of the specified Assessment on identified date in March, 2019, and the plan of care indicated that resident #001 had specified condition and required identified assistance. A review of the specified Report for June, 2019, did not include documentation at specified shift for identified tasks and interventions. Interview with PSW #108 identified that on an identified date in March, 2019, the assistance with identified tasks and interventions was provided but was not documented, which was acknowledged by the DOC on an identified date in July, 2019.

Interview with the DOC, on an identified date in July, 2019, identified that PSWs were expected to document tasks related to residents' care at the time of care.

The home failed to ensure that actions taken with respect to resident #001 under a specified program, including interventions and the resident's responses to interventions were documented.

B. Review of resident #002's plan of care indicated that the resident had specified condition and required identified assistance for specified activities. A review of the specified Report for an identified period of time from June to July, 2019, did not include documentation for identified tasks and interventions completed on identified dates in June and July, 2019, during specified shifts. Interview with PSW #109 and PSW #113

identified that the assistance was provided to resident #002 but it was not documented, which was acknowledged by the DOC on an identified date in July, 2019.

Interview with the DOC, on an identified date in July, 2019, identified that PSWs were expected to document tasks related to residents' care at the time of care.

The home failed to ensure that actions taken with respect to resident #002 under a specified program, including interventions and the resident's responses to interventions were documented.

C. Review of resident #003's plan of care indicated that the resident required identified assistance with identified tasks and interventions. A review of the specified Report on identified dates in June and July, 2019, did not include documentation related to identified tasks and interventions completed on identified dates in June and July, 2019, during specified shifts. Interview with PSW #112 and PSW #114 identified that the identified assistance was provided to resident #002 but it was not documented, which was acknowledged by the DOC on an identified date in July, 2019.

Interview with the DOC, on an identified date in July, 2019, identified that PSWs were expected to document tasks related to residents' care at the time of care.

The home failed to ensure that actions taken with respect to resident #003 under a specified program, including interventions and the resident's responses to interventions were documented. [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 and ensuring 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who had specified condition received an assessment, and that where the condition or circumstances of the resident required, an assessment was conducted using clinically appropriate assessment instrument that was specifically designed for assessment of specified condition.

Complaint log #007424-19 (IL-65704-HA/IL-66002-HA) submitted to the MOHLTC on an identified date in April, 2019, and CIS log #007038-19 (AH IL-65540-AH/CI 2364-000020 -19) submitted to the MOHLTC on an identified date in March, 2019, identified concerns related to the neglect of resident #001.

Review of resident #001's specified form did not include documentation on identified dates in March, 2019. Review of electronic specified Assessment indicated that the assessment was not completed.

On an identified date in July, 2019, PSW #105, indicated that during specified shifts on identified dates in March, 2019, resident #001 performed specified activity and they were not provided assistance.

Review of the specified Assessment and Plan of Care indicated that resident #001 had specified condition and required identified assistance. Review of the specified Procedure indicated that unregulated care provider was to complete the identified form. On an identified date in July, 2019, the Admission RN #102 indicated that the identified form was initiated and placed in a specified location for PSWs to complete for resident #001. Based on the identified form, the specified assessment was to be completed next. As per RN #102, PSWs were expected to check the binder and complete the identified form for resident #001, which was initiated but not completed, which was acknowledged by the ED. Progress note review indicted that resident #001 required identified assistance with all ADLs.

The home failed to ensure that resident #001, who had specified condition, received an assessment to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using clinically appropriate assessment instrument that was specifically designed for assessment of specified condition. [s. 51. (2) (a)]

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 ensuring that each resident who is incontinent receives an assessment that includes identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident requires, an assessment is conducted using clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #4: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, it was complied with.

In accordance with O. Reg. 79/10, s. 51, the licensee was required to have a specified program to promote specified condition.

Specifically, staff did not comply with the licensee's Interdisciplinary "LTC – Documentation" Policy, identifying that "a resident's record should be factual, internally consistent, concise and accurate and not include editorial comments, speculation or meaningless phrases".

Review of the specified Assessment and Plan of Care indicated that resident #001 had specified condition and required identified assistance.

A review of the specified Report on identified date in March, 2019, indicated that PSW #105 documented in identified tasks and interventions that resident #001 had specified activity and had identified condition during specified shift.

On an identified date in July, 2019, PSW #105 indicated that during specified shift on identified period of time in March, 2019, resident #001 performed specified activity and was not provided assistance with specified activity and the documentation on an identified date in March, 2019, was completed by mistake.

On an identified date in July, 2019, the DOC indicated that it was the home's expectation that PSWs document at the time of care and confirmed false documentation of specified task completed by PSW #105.

The home failed to ensure that "LTC – Documentation" Policy was complied with by the home's staff. [s. 8. (1) (b)]

Issued on this 21st day of August, 2019

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

Original report signed by the inspector.