Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Feb 7, 2022	2021_905683_0024	003153-21, 005193-21, 008360-21, 012565-21, 017280-21, 018827-21	Critical Incident System

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 Catherines ON L2N 1H2

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

LISA BOS (683), AILEEN GRABA (682), JENNIFER ALLEN (706480)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 15, 20-23, 2021, and January 6-7, 10-14, 2022.

This inspection was completed concurrently with complaint inspection #2021_905683_0023.

The following intakes were completed during this critical incident inspection:
Log #003153-21, CIS #2364-000006-21 was related to responsive behaviours and the prevention of abuse and neglect,
Log #005193-21, CIS #2364-000007-21 was related to the prevention of abuse and neglect;
Log #008360-21, CIS #2364-000009-21 was related to falls prevention and management;
Log #012565-21, CIS #2364-000017-21 was related to falls prevention and management;
Log #017280-21, CIS #2364-000029-21 was related to responsive behaviours and the prevention of abuse and neglect; and
Log #018827-21, CIS #2364-000035-21 was related to falls prevention and management.

NOTE: A Written Notification and Compliance Order related to LTCHA, s. 19 (1) was identified in this inspection and has been issued in concurrent inspection #2021_905683_0023.
A Written Notification and Voluntary Plan of Correction (VPC) related to Ontario Regulation 79/10 s. 8 (1) (b) was identified in concurrent inspection #2021_905683_0023 (log #017670-21) and was issued in this report.

During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Interim Director of Care (DOC), Associate Director of Care (ADOC), Recreation Manager, Environmental Manager, Payroll Manager, Infection Prevention and Control (IPAC)/Admission Lead, Behavioural Supports Ontario (BSO) staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, meal service, infection prevention and control (IPAC) practices, and reviewed clinical records, internal investigation notes, relevant policies and procedures and other pertinent documents.

Inspector #561 was also present during this inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **4 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 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).

Findings/Faits saillants :

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

A resident sustained a fall that resulted in an injury when they were ambulating with a mobility device.

The resident's care plan indicated that they required assistance to ambulate. A Registered Practical Nurse (RPN) documented that the resident was ambulating with a Personal Support Worker (PSW), and the fall occurred when the PSW stepped away from the resident to get something.

The interim Director of Care (DOC) acknowledged that at the time of the fall the resident was not provided the level of assistance with ambulating as indicated in their plan of care.

Because the care set out in the plan of care related to ambulation was not provided as specified, a resident sustained an injury.

Sources: A resident's electronic medical record; Critical Incident (CI) report; interview with a RPN, the DOC and other staff. [s. 6. (7)]

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, 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 has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with Ontario Regulation 79/10, s. 48 (1) 1 and in reference to O. Reg 79/10, s. 30 (1) 1, the licensee shall ensure that in respect of the organized falls prevention and management program there must be a written description of the program that includes relevant policies and that this is complied with.

Specifically, staff did not comply with the licensee's policy for Falls Prevention and Injury Reduction which stated that upon discovering a resident who fell, the resident was not be moved until an assessment was completed by the nurse.

A resident had a witnessed fall that resulted in an injury. Email correspondence and interviews with the PSWs who were present at the time of the fall indicated that the resident was not able to transfer themselves independently to their chair when they fell. They reported that they transferred the resident to their chair before the nurse came.

When the Registered Nurse (RN) arrived to complete the post fall assessment, they indicated that the resident had already been transferred from the floor and was sitting in a chair. They reported that the resident was transferred by the PSWs and that PSW staff were not to move any resident that fell until they were assessed by a nurse.

A resident was at risk for further injury/harm when the PSW staff did not comply with the home's policy and transferred the resident prior to a registered staff's assessment for injury.

Sources: CI report; the licensee's investigation notes (including emails); Fall Prevention and Injury Reduction - Post Fall Management Policy; a resident's electronic medical record; interviews with PSWs, a RN, the DOC and other staff. [s. 8. (1)]

2. The licensee has failed to ensure the Health Records and Interdisciplinary Documentation policy and procedures included in the required dietary service and hydration program were complied with, for a resident.

LTCHA s. 11 (1) (a) requires an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

O. Reg. 79/10, s. 68 (1) (d) requires that the program includes a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the home's Health Records and Interdisciplinary Documentation policy which stated that all documentation in the resident's health record would be accurate and that it would be written from first-hand knowledge, except in an emergency where one practitioner may be designated as the recorder.

A complaint was received regarding inaccurate documentation of resident food and fluid intake by staff members.

A PSW was observed feeding a resident. The resident ate their soup and had a beverage, and had a few teaspoons of their main course, as confirmed by the PSW who fed them. They reported that the resident ate less than 50% of their meal overall.

The Point of Care (POC) documentation was reviewed and a PSW documented that the resident consumed 75-100% of their meal.

The PSW who completed the documentation stated that they did not feed the resident and they assumed that they ate 75-100% of their meal because they normally ate well.

The Executive Director (ED) and Interim DOC acknowledged that the PSW who completed the documentation should not have assumed how much the resident ate and acknowledged that they did not follow the home's Health Records and Interdisciplinary Documentation Policy.

By assuming how much a resident ate, there was risk that poor food or fluid intake would go unnoticed, and that assessments by the Registered Dietitian would be inaccurate.

Sources: Dining observation; a resident's clinical record; Health Records and Interdisciplinary Documentation policy; interview with PSWs, the ED and the Interim DOC. [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 where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure interventions were developed to minimize the risk of altercations and potentially harmful interactions between and among residents.

A resident had a history of responsive behaviours towards co-residents. During a five-month period, there were seven documented instances of responsive behaviours focused towards co-residents. During this time, no new interventions were tried and/or updated to ensure safety of residents until after an incident where a co-resident sustained an injury and when the home re-referred to Behavioural Supports Ontario (BSO).

A PSW confirmed that the resident had frequent episodes of responsive behaviours occurring weekly or bi-weekly. A RN was aware of another incident where the resident was responsive to a co-resident.

There was risk of harm to co-residents when interventions for a resident's plan of care were not developed to mitigate further responsive behaviours.

Sources: A resident's plan of care; interview with the a PSW, BSO staff, a RN and the ADOC. [s. 55. (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 to ensure that interventions are developed to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

Six residents were observed leaving the dining room after lunch, and no hand hygiene was offered or provided.

A snack observation was completed, and five residents were served a snack without immediate prior assistance with hand hygiene. A PSW stated they did not usually wash the resident's hands before snack, just after lunch.

The home's Hand Hygiene policy did not explicitly reference hand hygiene for residents prior to and after eating. The Safe Eating Assistance document identified strategies to be considered when assisting residents with eating which included ensuring the resident's face and hands were washed prior to mealtime.

The failure to comply with the Hand Hygiene Program presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Hand Hygiene policy; Safe Eating Assistance document; observations; interview with a PSW and other staff. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 8th day of February, 2022

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

Original report signed by the inspector.