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: January 29, 2024
Inspection Number: 2024-1067-0001
Inspection Type: Complaint Critical Incident Follow-up
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Garden City Manor, St Catherines

Lead Inspector	**Inspector Digital Signature**
Betty Jean Hendricken (740884)	Elizabeth J Hendricken Digitally signed by Elizabeth J Hendricken Date: 2024.02.01 15:54:07 -05'00'

Additional Inspector(s)
Stephanie Smith (740738)
Stephany Kulis (000766)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 10 -12, 15, 16, 18, 19, 22 and 24, 2024
The inspection occurred offsite on the following date(s): January 12, 2024

The following intake(s) were inspected:

- Intake: #00091421/CI# 2364-000070-23 related to prevention of abuse and neglect.
- Intake: #00098491/CI# 2364-000087-23 related to skin and wound prevention and management.

- Intake: #00100246/CI #2364-000092-23 related to infection prevention and control.
- Intake: #00100477/CI# 2364-000093-23 related to resident care and support services.
- Intake: #00102100/CI #2364-000096-23 related to infection prevention and control.
- Intake: #00103149 - complaint related to resident care and support services.
- Intake: #00103259/CI #2364-000099-23 related to resident care and support services.
- Intake: #00104288 - follow-up to compliance order #001 from Inspection #2023-1067-0007 regarding FLTCA, 2021 - s. 6 (7) - Plan of Care.
- Intake: #00105129/CI #2364-000102-23 related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1067-0007 related to FLTCA, 2021, s. 6 (7) inspected by Stephany Kulis (000766)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

A. The licensee has failed to ensure that their pain management program was fully implemented to identify pain in a resident.

Rationale and Summary
A resident had a newly identified injury. Staff were monitoring the resident's pain and documented the resident's pain using a numerical pain scale.

Staff confirmed that a numerical pain scale would not be appropriate for the resident's cognitive level and that a Pain Assessment in Advanced Dementia (PAINAD) tool should have been used instead.

Failure to ensure that staff used the correct pain scale, put a resident at risk for unrecognized pain.

Sources: Resident clinical record, the home's Pain policy, interview with staff. [740738]

B. The licensee has failed to ensure that their pain management program was fully implemented to identify pain in a resident.

Rationale and Summary
A resident had a diagnosis of dementia and impaired cognitive status. Staff were monitoring the resident's pain and, on several occasions, assessed and documented the resident's pain using a numerical pain scale, requiring the resident to identify their pain on a scale of one to ten.

The home's Pain Assessment and Symptom Management Policy stated that all residents were to be assessed using a standardized, evidence-informed clinical tool that was appropriate for the resident's cognitive level.

A Physician confirmed that a numerical pain scale would not be appropriate for the resident's cognitive level because the resident did not have the cognitive ability to identify their pain on a scale of one to ten.

Failure to ensure that staff used the appropriate pain assessment tool, put the resident at risk for unrecognized pain.

Sources: Resident clinical record, the home's Pain Assessment and Symptom Management Policy (March 2023), interview with physician and DOC.
[740884]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee failed to ensure that a resident had an individualized blood glucose monitoring plan included in their plan of care.

A resident had a diagnosis of Type 2 Diabetes. According to the home's Diabetic Management Procedure, dated January 2022, all residents with diabetes were to have an individualized blood glucose monitoring plan in place.

Upon review of the resident's clinical record and in an interview with the Director of Care (DOC), it was confirmed that the resident did not have an individualized blood glucose monitoring plan in place.

Failure of the home to implement an individualized blood glucose monitoring plan could have contributed to a negative outcome for the resident.

Sources: Resident's clinical records, interview with DOC, Diabetic Management Procedure, dated January 2022.
[740884]

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from sexual abuse by a co-resident.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines "sexual abuse" as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale and Summary
On a date in July 2023, two residents were found by a staff member in an incident of a sexual nature. Staff intervened and re-directed the resident back to their room. There was no injury to the resident.

The resident was cognitively unaware of the incident and unable to provide consent to any touching or behaviour of a sexual nature.

Failure to protect the resident from sexual abuse by another resident, put the resident at risk of harm and abuse.

Sources: Resident's clinical records, CI: 2364-000070-23, interviews with staff and DOC.
[740738]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (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.

The licensee failed to ensure that any actions taken with respect to a resident under the Skin and Wound Care program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Rationale and Summary
On a date in September, 2023, a nurse changed a dressing to a wound. According to the home's Skin and Wound Re-Evaluation Procedure, the nurse was required to reassess the resident's wound during the dressing change, using the home's Skin and Wound Application.

The nurse failed to document the dressing change, including an assessment of the wound, interventions and the resident's responses to interventions in the resident's electronic Treatment Administration Record, progress notes and the home's Skin and Wound application.

Failure to document the dressing change could have led to deterioration in the wound for the resident.

Sources: Resident's clinical records, interview with the nurse and DOC, Skin and Wound Re-Evaluation Procedure dated May 10, 2023.
[740884]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

A. The licensee failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The Infection Prevention and Control Standard (IPAC) for Long-Term Care Homes, indicated under section 6.1 that Personal Protective Equipment (PPE) were to be followed in the IPAC program which required PPE to be available and accessible to staff and residents.

On a date in January 2024, a resident had contact precautions signage posted outside their room door, there was no PPE supplies/cart observed at point-of-care. Staff stated there was no PPE supplies available at point-of-care nor in the hallway of the unit, this was confirmed by observations. The resident's care plan provided direction for PPE to be available at point-of-care.

Failing to have the required personal protective equipment (PPE) posed a risk of spreading infection to other residents.

Sources: Interview with the staff; observation of a resident room; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022 and Revised September 2023.
[000766]
B. The licensee failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary

The Infection Prevention and Control Standard (IPAC) for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate selection and application.

On a date in January 2024, a resident had droplet precautions signage posted outside their room door. A staff member was observed entering the room wearing a gown, gloves and N95 mask. The staff entered the room without eye protection. The staff stated that when a resident is in droplet precautions, eye protection is to be worn.

Failing to put on the required personal protective equipment (PPE) posed a risk of spreading infection to other residents.

Sources: Observations and interview with the staff, observation of a resident room; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022 and Revised September 2023
[000766]