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
Nov 19, 2019	2019_704682_0031	014628-19, 015092-19, 016573-19, 016639-19, 017508-19, 017928-19, 020598-19	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. Catharines ON L2N 1H2

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

AILEEN GRABA (682)

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): October 30, 31, November 1, 5, 6, 7, 8, 12, 2019.

The following Critical Incident inspections were conducted:
020598 -19 related to fall prevention
015092 -19 related to fall prevention
016573 -19 related to prevention of abuse and neglect
017508 -19 related to prevention of abuse and neglect
017928 -19 related to fall prevention
014628 -19 related to prevention of abuse and neglect
016639 -19 related to fall prevention

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Director of Care/Staff Educator, Recreation staff, Registered Nursing staff, Personal Support Workers and residents.

During the course of this inspection, the inspector observed the provision of the care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, training records, program evaluations and policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 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 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 failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

A Critical Incident (CI) was submitted to the Director, related to resident #002.

A clinical record review of resident's #002 care plan, indicated resident #002 was identified as having a risk for falls and had various fall prevention strategies in place. During observations done by Inspector #682 on an identified date, resident #002 was observed without their fall prevention strategy in place. During an interview, staff #103 confirmed that the fall intervention was not in place for resident #002 but was included in their plan of care. During an interview, staff #106, stated that the fall intervention was put in place after the Inspector observations. Staff #103 and Staff #106 confirmed that the care set out in the plan of care related to resident #002 was not provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan.

A Critical Incident (CI) was submitted to the Director related to prevention of abuse and neglect. According to the CI, resident #008 was exhibiting responsive behaviours. A clinical record review of resident's #008 plan of care indicated that resident #008 had various strategies in place. During an interview, the DOC stated that they reviewed the incident on an identified date. Staff #120, was assigned to resident #008 and did not implement strategies identified in the care plan. The home did not ensure that the care set out in the plan of care was provided to the resident by staff #120 as specified in the plan related to their responsive behaviours. [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 failed to ensure that where the Act and 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 O. Reg. 79/10, s. 48 (1) 1, and in reference to O. Reg. 79/10, s. 49 (1), the licensee was required to have a falls prevention and management program that provided strategies to reduce or mitigate falls, including the monitoring of residents.

A Critical Incident (CI) was submitted to the Director related to resident #002.

A clinical record review of resident's #002 care plan indicated resident #002 was identified as having a fall risk. During an interview, staff #104 stated that the resident had responsive behaviours during identified dates. They also stated that resident #002 was identified to have these behaviours and had interventions in place. Staff #104 stated that resident #002 had exhibited the responsive behaviour again at an identified time. Staff #104 confirmed they did not witness the responsive behaviour and confirmed that they did not follow the home's policy regarding assessments. Staff #104 did not identify that the policy applied to the incident. During an interview staff #103 stated they had assessed resident #002 and identified an injury related to the incident.

During an interview, the DOC confirmed that resident #002 had responsive behaviours. They acknowledged that resident #002 sustained an injury. The DOC stated that because the resident sustained the injury, they expected staff to follow the home's policy related to assessments. The home failed to ensure that staff complied with the policy and initiate assessments. [s. 8. (1) (a),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 and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #002 had fallen, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident (CI) was submitted to the Director related to resident #002.

A clinical record review of resident's #002 care plan indicated resident #002 was identified as a fall risk with various fall interventions. During an interview, staff #104 stated that the resident stated that they did not witness the resident's fall. Staff #104 acknowledged they did not assess the resident after the incident and did not complete a post fall assessment using the clinically appropriate assessment instrument. During an interview, the DOC confirmed that when resident #002 was found on an identified date, the incidents were not witnessed. The DOC confirmed that resident #002 had sustained injuries. The home did not ensure that resident #002 was assessed by registered staff using a clinically appropriate assessment instrument when the resident was found. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use all equipment, in the home in accordance with manufacturer's instructions.

A Critical Incident (CI) log was submitted to the Director related to a fall sustained by resident #007.

A clinical record review indicated that resident #007 was identified as a fall risk, A review of resident's #007 care plan, identified various fall prevention strategies. During observation by Inspector #682, resident #007 had a fall interventions in place but was not applied in accordance with manufacturer's instructions. During an interview staff #110, confirmed that resident's #007 fall intervention was not applied in accordance with manufacturer's instructions and the resident remained a fall risk. During an interview, staff #108 identified the application of the fall interventions in accordance with manufacturer's instructions. The home did not ensure that staff applied the fall intervention in accordance with manufacturer's instructions. [s. 23.]

WN #5: 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 interventions related to falls preventions intervention for resident #002 completed by PSW staff were documented.

A Critical Incident (CI) was submitted to the Director related to resident #002.

A clinical record review of resident's #002 care plan indicated resident #002 was identified as having a risk for falls and had various fall prevention strategies. A review of the Point of Care (POC) tasks did not include any documentation or signatures that indicated resident #002 had fall interventions implemented on an identified date. A review of the paper chart also did not include documentation or signatures of the implementation of the fall intervention. During an interview staff #104 stated they initiated the fall intervention by verbally informing the staff. During an interview, the Director of Care (DOC) confirmed that they expected staff to create a task in point of care (POC) or by starting a paper form. The DOC confirmed that documentation regarding resident's #002 fall intervention was not done and the home did not ensure that resident #002 interventions related to fall prevention were documented. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for resident #004 demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and that the resident's responses to interventions were

documented.

A Critical Incident (CI) was submitted to the Director.

A clinical record review of resident's #003 current plan of care indicated that they exhibited responsive behaviours. Further review of a progress note indicated that resident #003 had an altercation with resident #004 that caused an injury. A clinical record review of resident's #004 plan of care, indicated they exhibit responsive behaviours. Further review of resident 's #004 clinical record did not include documentation related to actions taken related to the incident that occurred involving resident #003, including assessments, reassessments, interventions and responses to interventions.

During an interview, staff #105 confirmed that they assessed resident #004 post incident and should have documented their assessment, interventions and resident's #004 responses to interventions. During an interview the DOC stated they expected staff to document assessments in resident's #004 clinical records related to the incident. Staff #105 confirmed they did not ensure their actions taken to respond to the needs of resident #004 related to the incident were documented. [s. 53. (4) (c)]

2. The licensee failed to ensure that for resident #008 demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and that the resident's responses to interventions were documented.

A Critical Incident (CI) was submitted to the Director.

According to the CI, resident #008 was exhibiting responsive behaviours. A clinical record review did not include any documentation of the incident that occurred or actions taken by staff to respond to the resident needs, including assessments, reassessments and responses to interventions. During an interview staff #117 stated that they witnessed the incident but did not document what they witnessed or their actions related to the incident. During interviews, staff #115 and staff #116 confirmed that they did not witness the incident and did not document the incident in resident's #008 clinical record. During an interview, the DOC confirmed that for resident #008 demonstrating responsive behaviours, actions taken to respond to their needs, including assessments, reassessments and their responses to interventions were not documented. [s. 53. (4) (c)]

Issued on this 19th day of November, 2019

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

Original report signed by the inspector.