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
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Original Public Report

Report Issue Date: October 25, 2023	
Inspection Number: 2023-1067-0006	
Inspection Type: Complaint Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Garden City Manor, St Catharines	
Lead Inspector Tracey Delisle (741863)	**Inspector Digital Signature** Tracey DeLisle Digitally signed by Tracey DeLisle Date: 2023.11.29 11:25:15 -05'00'
Additional Inspector(s) Stephanie Smith (740738)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 27 - 29, and October 3 - 6, 2023.
The inspection occurred offsite on the following date(s): October 11, 13, 16 - 18, 2023.

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00002311 - Responsive behaviour: Resident to Resident.
- Intake: #00003602 - Verbal abuse: Resident to Resident.
- Intake: #00008741 - Physical abuse: Resident to Resident.
- Intake: #00016434 - Fracture, etiology unknown.

The following intake(s) were completed in this Complaint Inspection:

- Intake: #00096441 - Falls Prevention and Management Program.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee has failed 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 care set out in the plan has not been effective.

Specifically, the plan of care was not updated with new interventions as it relates to mitigating falls and injury from falls.

Rationale and Summary

A resident fell resulting in an injury requiring transfer to hospital. According to the Fall Risk Assessments reviewed, it was documented that the resident had multiple falls since admission.

According to the care plan, no new interventions had been added, and subsequently resident had a fall that resulted in injury.

It was confirmed in the Falls Prevention and Injury Reduction Meeting Minutes that no new interventions had been added to the care plan to prevent falls and injury. Staff confirmed there had been no new interventions added to the plan of care for the resident.

Failure to ensure that the resident's plan of care is updated with new interventions to mitigate falls, put the resident at risk of injury from falls and subsequently sustained an injury.

Sources: Interview with staff, Resident's clinical records, Falls Risk Screen, Post Fall Assessments, Falls Prevention and Injury Reduction Meeting Minutes, Continuous Review Policy #CARE5-O10.04. [741863]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect the resident from physical abuse by another resident.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

On a day in September 2022, resident #006 was reaching over resident #007's bed to turn on the shared room light. Resident #007 became agitated and pushed their assistive device into resident #006.

Resident #006 sustained an injury that required treatment. The residents were separated and resident #007 was placed on one-to-one supervision.

Failure to protect resident #006 from physical abuse by resident #007, led to actual harm to resident #006.

Sources: Resident #006 and #007's progress notes, resident #006's clinical record, Critical Incident, Interview with Staff (RN) #102. [740738]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to immediately report abuse of a resident by anyone that resulted in risk of harm to a resident.

Rationale and Summary

On a day in July 2022, a resident verbally threatened another resident. The residents were separated, and the one resident received one-to-one supervision. There were no further concerns and neither resident were harmed.

The Ministry of Long-Term After-Hours Reporting Line was not contacted. The Administration Staff

acknowledged that the incident occurred and was reported four days late.

Failure to report certain matters to the Director immediately had potential to put the residents at risk of harm or abuse.

Sources: Critical Incident, Interview with Administration Staff. [740738]

WRITTEN NOTIFICATION: Pain Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

It was recorded in the progress notes and critical incident report that the resident complained of pain and could not perform activities of daily living as usual.

According to the Home's Pain Assessment and Management Policy a "resident will be screened for pain using a Pain Screening tool (PAINAD, Numeric Rating Scale or Verbal Rating Scale, etc.) upon: New or Worsened Pain".

It was confirmed by two separate staff that the pain assessment tool was not completed on when the resident complained of pain. The resident was later transferred to hospital with a confirmed injury from unknown cause.

Failure to assess for pain using a Pain Screening tool put the resident at risk for increased pain.

Sources: Interview with staff, Policy # CARE8-O10.01 (Pain Assessment and Management), resident's clinical records, and Critical Incident. [741863]

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure for each resident demonstrating responsive behaviours, that the resident's responses to interventions were documented for resident #004.

Rationale and Summary

A Resident had a history of responsive behaviours, with identified triggers and interventions. Staff were required to document each shift in an electronic record to indicate if the resident had responsive behaviours and their response. Records from July 2022 indicated several shifts that were missing documentation for monitoring the resident's behaviours.

The Administration Staff acknowledged that there was missing documentation and that it should have been completed.

Failure to ensure that resident's responses to interventions for their responsive behaviours were documented, led to risk of staff being unaware if interventions were effective in reducing the resident's responsive behaviours.

Sources: Resident #004's clinical record, interview with DOC [740738]

WRITTEN NOTIFICATION: Reports Re: Critical Incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)

The licensee has failed to ensure when a significant change in the resident's health condition the Director is informed of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22 s. 115.

Rationale and Summary

A resident had a fall resulting in an injury requiring transfer to hospital. According to the care plan, the care needs for the resident resulted in a significant change and subsequently a Critical Incident was not reported to the Director and an investigation of the matter was not conducted.

During the inspection activities, it was confirmed by the staff that the provision of care changed for resident post fall.

Administration Staff confirmed that the critical incident was not reported.

Failure to report a Critical Incident to the Director and provide the required information regarding the incident immediately had potential to put the resident at increased risk of injury from falls.

Sources: Interview with staff, Resident's clinical records, Falls Risk Screen, Post Fall Assessments. [741863]