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: November 6, 2024

Inspection Number: 2024-1067-0003

Inspection Type:
Critical Incident
Follow up

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Garden City Manor, St Catharines

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 21-22, October 24, and October 28-30, 2024.

The following intakes were inspected:

- Intake #00115163/CI 2364-000015-24 was related to prevention of abuse and neglect.
- Intake #00117554-Follow-up #1- Compliance Order #001/2024_1067_0002-FLTCA, 2021 - s. 24 (1)- Duty to protect- CDD August 16, 2024.
- Intake #00120781/CI 2364-000021-24 was related to falls prevention and management.
- Intake #00122416/CI 2364-000023-24 was related to prevention of abuse and neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1067-0002 related to FLTCA, 2021, s. 24 (1) inspected by an inspector.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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 failed to protect a resident from physical abuse by another resident on an identified date.

Ontario Regulation 246/22 s. 2 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique")".

Rationale and Summary
On an identified date of May 2024, there was an altercation between two residents

that resulted in a resident being pushed to the ground. The resident was transferred by ambulance for further assessment due to sustained injuries.

Failure to protect a resident from physical abuse by another resident resulted in actual harm to the resident.

Sources: an identified resident's progress notes; an identified resident's progress notes and assessments; interviews with staff.

WRITTEN NOTIFICATION: Reports regarding critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 4. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee failed to ensure that the analysis and follow up action for long-term actions planned to correct the situation and prevent recurrence of injury to a resident was reported to the Director after there was an incident that caused injury with hospitalization and significant change to the resident condition.

Rationale and Summary
On an identified date in July 2024, a resident had a fall that resulted in hospitalization. The home submitted a critical incident report (CI) to the Director after

it was confirmed the incident resulted in injury and a significant change to the resident's health status. The report identified under the analysis and follow-up section that the resident was in hospital and a plan would be put in place on their return.

When the resident returned from hospital, a significant change assessment was completed by the home. The resident's plan of care was updated accordingly with newly assessed interventions.

The IPAC Manager and Executive Director acknowledged that the CI was not updated with the analysis and follow up action for long-term actions planned for the resident, and should have been.

Sources: CI Report; resident clinical record; interview with Executive Director and IPAC Manager.