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

Public Report

Report Issue Date: March 19, 2025
Inspection Number: 2025-1067-0002
Inspection Type: Complaint Critical Incident
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 date(s): March 6-7, 11-14 , 17-18, 2025

The following intake(s) were inspected:
-Intake: #00135446 -Critical Incident (CI) #2364-000041-24 - Prevention of abuse and neglect.
-Intake: #00135565 -CI #2364-000042-24 - Fall prevention and management.
-Intake: #00135636 - CI #2364-000043-24 - Prevention of abuse and neglect.
-Intake: #00139486 - Complainant related to prevention of abuse and neglect.

The following intake(s) were completed:
-Intake: #00140326 -CI #2364-000010-25 - Fall prevention and management.
-Intake: #00140650 -CI #2364-000012-25 - Fall prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall 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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised, when they demonstrated a new responsive behaviour towards a co-resident.

The Infection Prevention and Control (IPAC) Manager confirmed the plan of care had not been reviewed and revised, when the resident's care needs changed.

Remedy taken before conclusion of the inspection:
The IPAC Manager reviewed and revised the resident's electronic care plan to include the information noted above.

Sources: resident's plan of care including progress notes and care plan, and an

interview with the IPAC Manager.

Date Remedy Implemented: March 17, 2025

WRITTEN NOTIFICATION: General requirements

NC #002 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 organized program of nursing and personal support services, including interventions and the resident's response to interventions, were documented.

The home submitted a Critical Incident System (CIS), indicating that a resident had touched another resident, in a sexual manner on a specified date.

The resident's progress notes had not included details of the incident; which co-resident was involved; any potential contributing factors; what actions were taken.

When actions taken with respect to this resident, including interventions implemented, and the resident's response to interventions were not documented, this had a potential risk of staff not being aware of what occurred, all persons involved and if interventions were effective.

Sources: CIS #2364-000041-24; resident's progress notes; Risk Management report and an interview with the DOC.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee has failed to ensure that interventions were implemented for residents to minimize the risk of altercations and potentially harmful interactions.

a) A resident's clinical record indicated they had an intervention in place due to a responsive behaviour. This intervention had been discontinued and on two separate instances the resident demonstrated their responsive behaviour. The intervention was not reinitiated and the DOC acknowledged this should have been.

b) During an interview with the DOC, it was indicated that staff were to re-direct a resident away from a co resident. They confirmed this intervention had not been implemented into the plan of care for the resident.

When interventions are not implemented following a responsive behaviour incident, this has the potential risk for altercations and potentially harmful interactions to occur again.

Sources: CIS #2364-000041-24; resident's progress notes, care plan and an interview with the DOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use as specified by the prescriber. There was no documentation indicating that the medication was given as ordered.

Sources: Resident's clinical records, interview with Registered Nurse (RN) and IPAC lead.

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