



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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
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Bureau régional de services de Hamilton
119, rue King Ouest, 11ième étage
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Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Table with 4 columns: Report Date(s) / Date(s) du Rapport, Inspection No / No de l'inspection, Log # / Registre no, Type of Inspection / Genre d'inspection. Row 1: Mar 5, 2014, 2014\_247508\_0003, H-000905-13/H-000933, Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

**Inspection Report under  
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Loi de 2007 sur les foyers de  
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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): February 6,7,10,11,12 and 13, 2014**

**This inspection was done concurrently with 2014\_240506\_0003**

**During the course of the inspection, the inspector(s) spoke with Associate Director of Care(ADOC),RAI-Co-ordinator,Registered Nursing Staff,Personal Support Workers(PSW),and Residents.**

**During the course of the inspection, the inspector(s) toured the home,observed provision of care and services provided, and reviewed relevant documents including,but not limited to: policies and procedures and clinical records.**

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

**Findings of Non-Compliance were found during this inspection.**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

|   |  |
|---|--|
| <p>Legend</p> <p>WN – Written Notification<br/> VPC – Voluntary Plan of Correction<br/> DR – Director Referral<br/> CO – Compliance Order<br/> WAO – Work and Activity Order</p>  | <p>Legendé</p> <p>WN – Avis écrit<br/> VPC – Plan de redressement volontaire<br/> DR – Aiguillage au directeur<br/> CO – Ordre de conformité<br/> WAO – Ordres : travaux et activités</p>  |
| <p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (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. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**



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1. The licensee failed to protect residents from abuse by anyone and to ensure that residents were not neglected by the licensee or staff.

Previously issued on 2012/05/11-VPC

Resident #009 was identified as having responsive behaviours towards other residents. Interventions were developed prior to an incident on an unidentified date in 2013, where resident #008 sustained an injury. The resident's plan of care indicated the interventions to deal with resident #009's behaviours had proven ineffective both before and after the incident. The resident's plan of care did not get reassessed or updated to address the on-going responsive behaviours documented in the clinical record. According to resident #009's clinical record, the responsive behaviours continue to occur involving other residents that reside on the unit.

It was confirmed by staff that there has been no reassessment of the current interventions that have been ineffective. [s. 19. (1)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).**

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**Findings/Faits saillants :**



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1. The licensee failed to ensure that when a resident was restrained by a physical device as described in paragraph 3 of subsection 30 (1) the restraining of the resident was included in the resident's plan of care.

On an unidentified date in 2014, it was observed that resident #011 was awake and dressed sitting in a wheelchair with a lap belt applied. Staff confirmed that the wheelchair resident #011 was seated in belonged to another resident. Staff indicated that resident #011 would not stay in bed and wanted to get up. Staff put the resident in the wheelchair with the lap belt on to prevent resident #011 from walking due to the resident's unsteadiness.

The resident's plan of care did not include an intervention for the use of the lap belt. There was no documentation in the clinical records to indicate that the resident required the use of an emergency physical device.

The RN in charge of the building indicated that she was not aware that the resident had been restrained and confirmed that the resident did not have an order for the lap belt.

The RPN confirmed that she was notified by the PSW staff that the resident was restrained in the wheelchair and no assessment had been completed.

It was confirmed by the ADOC that the resident should not have been restrained and that the resident would not be able to release the lap belt independently. [s. 31. (1)]

***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 be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**



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Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

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**Findings/Faits saillants :**

1. The licensee failed to ensure that when there were reasonable grounds to suspect abuse by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately report the suspicion and the information upon which it was based on to the Director.

According to the Critical Incident report and the home's investigation notes, the licensee was aware of the alleged abuse on an unidentified date in 2013. The Critical Incident report was not submitted to the Director until four days after the alleged incident.

It was confirmed by the Associate Director of Care that the Critical Incident report was submitted four days after the incident, after the investigation was conducted. [s. 24.

(1)]



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Issued on this 6th day of March, 2014

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

*Roseanne Western*



Ministry of Health and  
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Order(s) of the Inspector  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité

**Public Copy/Copie du public**

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Name of Inspector (ID #) /  
Nom de l'inspecteur (No) : ROSEANNE WESTERN (508)

Inspection No. /  
No de l'inspection : 2014\_247508\_0003

Log No. /  
Registre no: H-000905-13/H-000933-13

Type of Inspection /  
Genre  
d'inspection: Critical Incident System

Report Date(s) /  
Date(s) du Rapport : Mar 5, 2014

Licensee /  
Titulaire de permis : REVERA LONG TERM CARE INC.  
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA,  
ON, L5R-4B2

LTC Home /  
Foyer de SLD : GARDEN CITY MANOR  
168 Scott Street, St. Catharines, ON, L2N-1H2

Name of Administrator /  
Nom de l'administratrice  
ou de l'administrateur : KIM WIDDICOMBE

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To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:





Ministry of Health and  
Long-Term Care

Ministère de la Santé et  
des Soins de longue durée

Order(s) of the Inspector  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

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**Order # /**

**Ordre no :** 001

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan that ensures that the resident's plan of care includes interventions that minimize risk of injury to other residents.

The plan shall be submitted electronically to Roseanne Western at [Roseanne.Western@ontario.ca](mailto:Roseanne.Western@ontario.ca) by March 28, 2014.

**Grounds / Motifs :**



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**Order(s) of the Inspector**  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
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**Ministère de la Santé et  
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**Ordre(s) de l'inspecteur**  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee failed to protect residents from abuse by anyone and to ensure that residents were not neglected by the licensee or staff.

Previously issued on 2012/05/11 as a VPC

Resident #009 was identified as having responsive behaviours towards other residents. Interventions were developed prior to an incident on an unidentified date in 2013, where resident #008 sustained an injury. The resident's plan of care indicated that interventions to deal with the resident's responsive behaviours had proven ineffective both before and after the incident. The resident's plan of care did not get reassessed or updated to address the on-going responsive behaviours documented in the clinical record. According to resident #009's clinical record, the responsive behaviours continue to occur involving other residents that reside on the unit.

It was confirmed by the ADOC that there has been no reassessment of the current interventions that have been ineffective.

(508)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le : Mar 28, 2014**



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Ordre(s) de l'inspecteur  
Aux termes de l'article 153 et/ou  
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de soins de longue durée*, L.O. 2007, chap. 8

### **REVIEW/APPEAL INFORMATION**

#### TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
TORONTO, ON  
M5S-2B1  
Fax: 416-327-7603



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de soins de longue durée*, L.O. 2007, chap. 8

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar  
151 Bloor Street West  
9th Floor  
Toronto, ON M5S 2T5

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance  
Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
TORONTO, ON  
M5S-2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).



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section 154 of the *Long-Term Care  
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Ordre(s) de l'inspecteur  
Aux termes de l'article 153 et/ou  
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## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

### PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto (Ontario) M5S 2T5

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la  
conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11e étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au [www.hsarb.on.ca](http://www.hsarb.on.ca).

Issued on this 5th day of March, 2014

Signature of Inspector /  
Signature de l'inspecteur :

Name of Inspector /  
Nom de l'inspecteur :

Roseanne Western

Service Area Office /

Bureau régional de services : Hamilton Service Area Office