Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 7, 2022	2021_905683_0023	017670-21, 020114-21, 020223-21	Complaint

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 Catherines ON L2N 1H2

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

LISA BOS (683)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 15, 20-23, 2021, and January 6-7, 10-14, 2022.

This inspection was completed concurrently with critical incident inspection #2021_905683_0024.

The following intakes were completed during this complaint inspection:
Log #017670-21 was related to dining, continence care and bowel management, and the prevention of abuse and neglect;
Log #020114-21 was related to responsive behaviours and the prevention of abuse and neglect; and
Log #020223-21 was related to responsive behaviours and the prevention of abuse and neglect.

NOTE: A written notification and Voluntary Plan of Correction related to O. Reg. 79/10 s. 8 (1) (b) was identified in this inspection and has been issued in concurrent inspection #2021_905683_0024.
A Written Notification and Compliance Order related to LTCHA s. 19 (1) was identified in concurrent inspection #2021_905683_0024 (log #01728-021) and was issued in this report.

During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Interim Director of Care (DOC), Associate Director of Care (ADOC), Niagara Regional Police Detective, Recreation Manager, Environmental Manager, Payroll Manager, Infection Prevention and Control (IPAC)/Admission Lead, Behavioural Supports Ontario (BSO) staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, meal service, infection prevention and control (IPAC) practices, and reviewed clinical records, internal investigation notes, relevant policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 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 :

1. The licensee has failed to ensure that residents were protected from physical abuse by

other residents.

Ontario Regulation 79/10 s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A) A resident wandered into a co-resident's room and there was an altercation which resulted in serious injury to the co-resident.

The interim Director of Care (DOC) acknowledged that a resident sustained an injury as a result of the incident and that they were not protected from physical abuse by another resident.

Sources: Resident clinical records; internal investigation notes; interview with the interim DOC and other staff. [s. 19. (1)]

B) There was an altercation between two residents which resulted in injury to a resident.

One of the residents had a history of responsive behaviours towards co-residents.

The home's Responsive Behaviour Procedure identified that when a resident displayed any physical responsive or verbally threatening behaviour, the Registered staff were to complete a Responsive Behavioural Huddle, which would trigger the resident to be added to the weekly responsive behaviour round tool.

The registered staff did not compete the Responsive Behavioural Huddle in Point Click Care (PCC) between a five-month period when a resident demonstrated physical responsive or verbally threatening behaviour towards co-residents. This assessment would have alerted the Responsive Behaviour Committee to focus discussions during the weekly responsive behaviour rounds relating to the resident's behaviours, triggers and effective or ineffective interventions.

When inspectors asked to review the weekly responsive behaviour round tool for a resident for each of the physical responsive or verbally threatening behaviours identified in the progress notes, the Recreation Manager, who was the lead for the Responsive Behaviour Committee, was unable to produce the records.

Failure to complete the Responsive Behavioural Huddle and weekly responsive behaviour round tool put residents at risk of physical or verbal abuse when a resident

continued to display physically responsive or verbally threatening behaviours and were not reviewed by the team.

Sources: Resident care plans; Critical Incident report; Responsive Behaviour Procedure Policy; interview with the Recreation Manager and other staff. (706480) [s. 19. (1)]

Additional Required Actions:

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

Issued on this 8th day of February, 2022

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA BOS (683)
Inspection No. / No de l'inspection :	2021_905683_0023
Log No. / No de registre :	017670-21, 020114-21, 020223-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 7, 2022
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Garden City Manor 168 Scott Street, St Catherines, ON, L2N-1H2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Helen VanDyk

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

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 must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee must:
1. Ensure that a specific resident and all other residents are protected from physical abuse by co-residents.
2. Ensure that two specific residents do not physically abuse co-residents.
3. Ensure that staff complete the Responsive Behavioural Huddle for a specific resident when indicated, as per the home's Responsive Behavioural Procedure.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from physical abuse by other residents.

Ontario Regulation 79/10 s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A) A resident wandered into a room and there was an altercation which resulted in serious injury to a co-resident.

The interim Director of Care (DOC) acknowledged that a resident sustained an injury as a result of the incident and that they were not protected from physical abuse by another resident.

Sources: Resident clinical records; internal investigation notes; interview with the interim DOC and other staff.

B) There was an altercation between two residents which resulted in injury to a

resident.

One of the residents had a history of responsive behaviours towards co-residents.

The home's Responsive Behaviour Procedure identified that when a resident displayed any physical responsive or verbally threatening behaviour, the Registered staff were to complete a Responsive Behavioural Huddle, which would trigger the resident to be added to the weekly responsive behaviour round tool.

The registered staff did not compete the Responsive Behavioural Huddle in Point Click Care (PCC) between a five-month period when a resident demonstrated physical responsive or verbally threatening behaviour towards co-residents. This assessment would have alerted the Responsive Behaviour Committee to focus discussions during the weekly responsive behaviour rounds relating to the resident's behaviours, triggers and effective or ineffective interventions.

When inspectors asked to review the weekly responsive behaviour round tool for a resident for each of the physical responsive or verbally threatening behaviours identified in the progress notes, the Recreation Manager, who was the lead for the Responsive Behaviour Committee, was unable to produce the records.

Failure to complete the Responsive Behavioural Huddle and weekly responsive behaviour round tool put residents at risk of physical or verbal abuse when a resident continued to display physically responsive or verbally threatening behaviours and were not reviewed by the team.

Sources: Resident care plans; Critical Incident report; Responsive Behaviour Procedure Policy; interview with the Recreation Manager and other staff. (706480)

An order was made by taking the following factors into account:

Severity: A resident physically abused another resident, causing serious injury.

Scope: The scope was isolated as two out of six residents reviewed identified abuse.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 19 (1) and two Voluntary Plans of Correction (VPCs) were issued to the home. (683)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2022

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of February, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Bos

Service Area Office /
Bureau régional de services : Hamilton Service Area Office