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
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Original Public Report

Report Issue Date: December 1, 2022

Inspection Number: 2022-1067-0001

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Revera Long Term Care Inc.

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

Lead Inspector	**Inspector Digital Signature**
Erin Denton-O'Neill (740861)	Erin Denton-O'Neill Digitally signed by Erin Denton-O'Neill Date: 2022.12.13 11:14:09 -05'00'

Additional Inspector(s)
Yuliya Fedotova (632)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

November 9-10, 14-16, 21-23, 2022

The following intake(s) were inspected:

- Intake: #00005691-High Priority - Follow-up to CO#001 from inspection #2021_905683_0023 / 017670-21, 020114-21, 020223-21 regarding s. 19. (1), CDD Mar 09, 2022
- Intake: #00005962- (complaint) related to Resident Care and Support Services
- Intake: #00011347-2364-000045-22 – related to Falls Prevention and Management

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
LTCHA, 2007 S.O. 2007,	s. 19. (1)	2021_905683_0023	#001	#632

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

Infection Prevention and Control
Falls Prevention and Management
Prevention of Abuse and Neglect
Food, Nutrition and Hydration
Continence Care
Housekeeping, Laundry, and Maintenance Services
Resident Care and Support Services
Medication Management

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 (1) (a)

The licensee has failed to ensure that there was a written plan of care for each resident that sets out, the planned care for the resident in terms of the mobility.

Rationale and Summary

During the inspection, it was observed that a resident always used a wheelchair for locomotion in the home. The most recent physiotherapy assessment identified that the resident required a wheelchair for functional mobility, which was confirmed by the physiotherapist. The

interventions at the time of the inspection identified the resident used a walker to ambulate and a wheelchair on some occasions.

A staff member confirmed that the resident's plan of care for mobility interventions were not updated based on the physiotherapy assessments.

Sources: Resident's written plan of care, physiotherapy assessment, resident observations, interviews with physiotherapist and Infection Prevention and Control manager.

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WRITTEN NOTIFICATION: Plan of care - involving resident

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A resident's progress notes and Risk Management Report review for a specified time identified that on 13 occasions the resident's substitute decision-maker was not notified when the resident had falls, which was confirmed by the Associate Director of Care (ADOC). By not notifying the substitute decision-maker they were not able to make informative decisions when participating in the development and implementation of the resident's plan of care

Sources: Resident's progress notes and Risk Management Reports, interview with the ADOC.

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WRITTEN NOTIFICATION: Medication Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 140 (2)

The licensee failed to ensure that a resident received their medication as prescribed weekly.

Rationale and Summary

A resident was ordered a medication on a specific day of the week. On two occasions the medication was not in the home on the prescribed dates therefore not given to the resident as ordered. Physician confirmed that the resident did not receive the medication on the prescribed dates.

When the resident does not receive their medications as prescribed, there is a risk of the resident receiving ineffective symptom management.

Sources: Interviews with pharmacist, physician and staff, record review of the resident's clinical record and drug record book.

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