



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

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

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

**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**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|--------------------------------|--|
| Apr 10, 2015 | 2014_300560_0016 | H-001079-14 | Complaint |

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

SUSAN PORTEOUS (560)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): October 8, 9, 10, 2014.

**This was an off-site inspection conducted by telephone of complaint log #
H-001079-14.**

**During the course of the inspection, the inspector(s) spoke with the complainant,
Administrator, Director of Care (DOC) and Community Care Access Center (CCAC)
staff and reviewed the resident's clinical record and other relevant documents.**

**The following Inspection Protocols were used during this inspection:
Admission and Discharge**

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

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| Legend | Legendé |
|---|--|
| WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order | 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). | 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. |
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | 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 O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident



Specifically failed to comply with the following:

- s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,**
- (a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).**
 - (b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).**
 - (c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).**
 - (d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).**

Findings/Faits saillants :



The licensee failed to ensure that before discharging resident #001 under O.Reg.79/10 s. 145(1) that the licensee provided a written notice to the resident and their substitute decision-maker setting out a detailed explanation of the supporting facts, as related both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident [O.Reg. 79/10 s. 148(2)(d)].

1. The inspector reviewed resident #001's clinical record and the following information was identified:

(a) On an identified date resident #001 pushed the wheelchair of another resident and caused the other resident to sustain a serious injury. Resident # 001 had a history of aggressive physical behavior towards staff and other residents. The resident's attending physician was notified of the incident and completed a Form 1 for the resident.

(b) The next day the resident was transferred to hospital on the psychiatric Form 1.

(c) The following day, the attending physician ordered the resident's discharge from the home. At the time of discharge the resident remained a patient in the hospital.

2. The DOC confirmed during an interview with the inspector that a written notice of discharge was not provided to the resident or the resident's power of attorney before the resident was discharged from the home. [s. 148. (2)]

Issued on this 16th day of April, 2015

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

Original report signed by the inspector.