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

Original Public Report

Report Issue Date: May 30, 2024	
Inspection Number: 2024-1067-0002	
Inspection Type: Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Garden City Manor, St Catharines	
Lead Inspector Jonathan Conti (740882)	**Inspector Digital Signature** Jonathan Conti Digitally signed by Jonathan Conti Date: 2024.06.27 15:09:24 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 13-16, 21-24, 27, 2024

The following intakes were inspected for the Critical Incident (CI) inspection:

- Intake: #00105911/CI 2364-000001-24- prevention of abuse and neglect.
- Intake: #00108136/CI 2364-000005-24- prevention of abuse and neglect.
- Intake: #00110368/CI 2364-000010-24- prevention of abuse and neglect.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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) (c)
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,
(c) care set out in the plan has not been effective.

The licensee failed to ensure that a resident was reassessed and the plan of care reviewed when care set out in the plan has not been effective.

Rationale and Summary
A resident was injured due to a fall. As a result, the resident had identified care instructions put in place to decrease their risk of injury related to falls as recommended by the physician and fracture clinic.

On an identified date, the resident was observed without having the identified care instructions being followed. Staff confirmed that the identified care instructions were not in place due to resident refusal. Staff attempted to offer the resident the identified care needs, however the resident again refused.

Registered staff confirmed the refusal of the identified care instructions was an ongoing issue and that the resident plan of care should have been updated to state

such. The plan of care was then reviewed by registered staff after an assessment of the resident, and it was revised to state for the identified care instructions to be provided as tolerated.

The Director of Care (DOC) confirmed that the intervention for the resident was not changed in the plan of care until brought forward by the inspector. The DOC acknowledged that it was known that the original identified care instructions were not effective and should have been updated prior. The plan of care was updated accordingly, and monitoring put in place for use of the identified intervention.

Sources: Interview with staff; observations on a date in 2024; resident clinical record and plan of care. [740882]

Date Remedy Implemented: May 15, 2024

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible.

The licensee has failed to ensure that strategies to mitigate and respond to resident #001's responsive behaviours were implemented.

Rationale and Summary
Resident #001 was under 1:1 monitoring by an assigned agency Personal Support Worker (PSW), due to their history of physical and verbal responsive behaviours towards staff and residents. Resident #001 was with their assigned 1:1 staff member in an identified location on an identified date. Resident #001 wandered from the identified location to a second location without the assigned 1:1 staff member following them. Resident #002 was present in second location at the time, along with another co-resident and that co-resident's 1:1 staff member.

At an identified time, resident #001 showed inappropriate behaviour to resident #002, which resulted in physical injury to resident #002. The residents were separated, and registered staff assessed both residents.

As per the home's procedure "Responsive Behaviour One to One", dated April 30, 2023, the 1:1 monitoring of residents would be implemented when there is an incident of risk. The expectations of the 1:1 staff is that they are not to leave their assignment and stay with the assigned resident.

There was a risk that resident #001 would exhibit physically responsive behaviours when their assigned 1:1 PSW was not close and monitoring them.

Sources: Interviews with RN and DOC; clinical records including plan of care and progress notes; BSO-DOS charting; the home's procedure titled "Responsive Behaviour One to One" (dated April 30, 2023). [740882]

WRITTEN NOTIFICATION: Behaviours and altercations

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The licensee failed to ensure that the procedures and interventions developed were implemented to assist residents and staff who are at risk of harm as a result of a resident's behaviours.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was to develop and implement procedures and interventions to assist residents and staff who are at risk of harm as a result of resident's behaviours, including responsive behaviours, in effort to minimize the risk of altercations and potentially harmful interactions between and among residents, and that the procedure is complied with.

The licensee failed to implement their Responsive Behaviour procedure which outlines that staff are to complete a specified assessment for identified behaviours, and to initiate monitoring and tracking tools.

On a date in January 2024, resident #005 had physically responsive behaviours towards staff when they tried to separate the resident from another. Staff then completed a specified assessment that identified the behaviour was a new physical behaviour, however they did not initiate the required monitoring or tracking tools as per the home's procedures.

On a date in February 2024, there was a physical responsive behaviour by resident #005 that resulted in an injury to resident #004, and required the initiation of 1:1 monitoring and use of BSO-DOS charting.

Staff confirmed BSO-DOS charting would be initiated if a new behaviour occurred to help determine further needs of the resident, and that the initiation of 1:1 monitoring would be considered if ongoing concerns or there was a significant risk to resident safety. RN #108 acknowledged that BSO-DOS charting could have been initiated in January 2024 for resident #005 to track behaviours to determine further intervention.

The DOC acknowledged that procedures as written were not implemented for resident #005's new physical responsive behaviour on the identified date in January 2024.

The home's failure to implement their procedure of 1:1 monitoring and a behavioural monitoring tool for resident #005's new physical responsive behaviour on a specified date in January 2024 may have resulted in an incomplete assessment of the resident's responsive behaviours and posed a risk of further altercations with residents.

Sources: Resident #005 progress notes and assessments; the home's procedure titled "Responsive Behaviour Procedure" (modified date March 31, 2020); interviews with DOC and RN. [740882]

COMPLIANCE ORDER CO #001 Duty to protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1. The licensee shall provide education for all Personal Support Workers and Registered Nursing staff on specified units on the LTCH's policies and procedures for Prevention of Abuse and Neglect, and for Responsive Behaviours, including the home's responsive behaviour 1:1 (one to one) processes and procedures; and
2. Document the education, including the date(s) it was held, the staff members who attended, and the staff's signatures that they understood the education; and
3. Maintain written records of the education provided and the list of staff who received and completed the education. All written records must be available on request.

Grounds

1) The licensee failed to ensure that resident #002 was protected from physical abuse by resident #001.

As per O. Reg. 246/22, s. 2(1), "physical abuse" from resident to resident is defined as the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique").

Rationale and Summary

A resident had a known history of physical responsive behaviours between staff and co-residents. The plan of care for the resident included that they were on a Behavioural Support Ontario- Dementia Observation System Behaviour Tracking Tool (BSO-DOS) and were to receive one-to-one (1:1) monitoring.

On a specified date in January 2024, the resident entered a location without the presence of their 1:1 staff member and had a physical altercation with another resident. A staff member monitoring another co-resident intervened and the two residents were separated.

Registered staff separated the resident's and assessed for injuries. The other resident was noted to sustain injuries that were treated by staff. Both residents involved were put on 1:1 monitoring, pain monitoring, and BSO-DOS charting for 72hours.

The Registered Nurse (RN) and Director of Care (DOC) confirmed that the 1:1 staff member responsible for monitoring the resident was not present for the incident or within the location.

Failing to protect a resident from physical abuse by another resident caused physical injury and presented a risk to resident safety.

Sources: Interviews with staff; resident clinical records [740882]

2) The licensee failed to ensure that a resident was protected from physical abuse by another resident.

As per O. Reg. 246/22, s. 2(1), "physical abuse" from resident to resident is defined as the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique").

Rationale and Summary

A resident with a history of physically responsive behaviours towards co-residents was being monitored by a 1:1 staff member to prevent altercations. On an identified date in February 2024, the resident had physically responsive behaviours with their 1:1 staff member and proceeded to wander to another location. The resident had a physical altercation with another resident.

Both residents were separated by the 1:1 staff and registered staff were required to call a code white due to the resident's physical aggression and hitting out at staff. The second resident was assessed by staff and sustained an identified injury.

The Registered Nurse (RN) #110 and Director of Care (DOC) acknowledged that the physical altercation was initiated when the resident entered the space another resident was in and that the other resident received injuries.

Failing to protect a resident from physical abuse by another resident caused physical injury and presented a risk to resident safety.

Sources: Interviews with staff; resident clinical records; risk management report; CIS report. [740882]

3) The licensee failed to ensure that a resident was protected from physical abuse by another resident.

As per O. Reg. 246/22, s. 2(1), "physical abuse" from resident to resident is defined as the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique").

Rationale and Summary

On a specified date in February 2024, a resident was seated in a chair at the nursing station when another resident walked towards and started yelling at the seated resident. Staff heard the verbal altercation between the two residents from down the hall, and as they were approaching the residents, it was witnessed that the seated resident kicked the leg of the device the second resident was holding, and the second resident fell with injury being sustained.

Both residents' were separated, assessed by registered staff, and 1:1 monitoring was put into place for the resident with a behavioural tracking tool initiated as well.

The resident with injury was sent to hospital and returned with confirmed injury requiring specified care directions

The DOC acknowledged that by the resident using physical force to kick the device the other resident was holding onto, that resident then lost their balance and fell resulting in physical injury and pain.

Failure to protect a resident from physical abuse by another resident caused physical injury and presented a risk to resident safety.

Sources: Resident clinical records including progress notes, plan of care, assessments, medication records; CI report 2364-000005-24; interviews with staff. [740882]

This order must be complied with by August 16, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay

the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the

order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.