Ontario

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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 31, 2017;	2016_205129_0015 (A1)	029648-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

Long-Term Care Home/Foyer de soins de longue durée

BRIERWOOD GARDENS
425 PARK ROAD NORTH BRANTFORD ON N3R 7G5

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

Ontario

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 prévue le Loi de 2007 les foyers de soins de longue durée

PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The date to comply with the required training in Order #001 has been amended to October 6, 2017

Issued on this 31 day of August 2017 (A1)

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

Original report signed by the inspector.

Ontario

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 prévue le Loi de 2007 les foyers de soins de longue durée

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

PHYLLIS HILTZ-BONTJE (129) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): October 6, November 23, 24, 25, 28, 29, 30, December 1, 13, 14 and 15, 2016

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Associate Director of Care (ADOC), the former DOC and registered staff.

During the course of this inspection the inspector toured the home, observed medication administration, reviewed relevant records including home's investigative notes, resident health records, logs maintained by the home, staffing schedule and the home's staffing plan, service provider contracts, home policies and procedures and conducted interviews.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Medication

Reporting and Complaints

Sufficient Staffing

Training and Orientation

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

8 WN(s)
6 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	Legendé 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.
Resident #001 was administered a drug that was not in accordance with the directions for use specified by the resident's physician. Resident #001's physician wrote an order on an identified date, to administer a specific drug, identified the specific dose of the drug to be administered and the time frequency in which the drug was to be administered. Documentation in the resident's plan of care, specifically the electronic progress notes indicated that registered staff #603, who worked in the home pursuant to a contract with an employment agency, administered two doses of the drug on an identified date and the time frequency between the two doses of the drug were not in accordance with the time frequency specified by the resident's physician. Registered staff #606 and medication administration records maintained by the home confirmed that the drug specifically provided for this resident indicated that the resident had received two doses of the drug within a time frequency that was not in accordance with the time frequency specified by the resident's physician.
The licensee failed to ensure that resident #001 was administered a drug in accordance with the directions specified by the resident's physician. [s. 131. (2)]

2. The licensee failed to ensure that no person administered a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.
The licensee failed to ensure that staff #607 met the requirements, identified in the LTCH Act. 2007, to administered medications to residents. Staff # 607 accepted a position in the home as a Registered Practical Nurse (RPN), was first assigned to

perform those duties on an identified date in 2014 and worked in the home for seven months. The Executive Director (ED) and records provided by the home confirmed that staff #607 did not hold a certificate of registration from the College of Nurses of Ontario (CNO) for five of the seven months they worked in the home and therefore could not use the title RPN or perform the duties and responsibilities of an RPN during those five months.
The clinical record, specifically the Medication Administration Record (MAR), confirmed that staff #607 administered drugs to resident #008, resident #003 and resident #002 during the above noted five month period of time.
As staff #607 did not hold a certificate of registration as a RPN or a Registered Nurse (RN) when they administered drugs to resident #008, resident #003 and resident #002, the licensee did not ensure that drugs that were administered by only a Physician, Dentist, RN or RPN. [s. 131. (3)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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 and ensuring that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change.

Staff in the home did not revise resident #001's plan of care when documentation made by staff indicated the resident's care needs had changed. Clinical documentation reviewed over a period of one month in 2016, indicated the resident's care needs had changed in five identified care areas. A review of the plan of care, specifically, care directions to staff confirmed that the care directions for staff in the identified care areas were not revised to reflect the noted change in the resident's needs and abilities.
Registered staff #601 reviewed the resident's plan of care and confirmed the care directions for resident #001 had not been revised to reflect the changing needs of the resident. [s. 6. (10) (b)]

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 and ensuring that residents are reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

Findings/Faits saillants :

1. The licensee failed to ensure that every member of the staff who performs duties in the capacity of Registered Nurse or Registered Practical Nurse had the appropriate current certificate of registration with the College of Nurses of Ontario.

a) Registered Nurses (RNs) # 603, #604 and #605 worked at the long term care home as agency RNs, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request.

RNs # 603, #604 and # 605 were identified as "staff" according to the interpretation of "staff" in the LTCHA, 2007, as a person who worked at the home, pursuant to a contract or agreement between the, licensee and an employment agency or other third party.

RN # 603 first performed the duties of a RN in the home on an identified date in 2015 and continued to work in this capacity for 22 subsequent shifts. RN #604 first performed the duties of a RN in the home on an identified dated in 2016, and then did not return to work in the home. RN # 605 first performed the duties of a RN in the home on an identified dated in 2016 and continued to work in this capacity for three subsequent shifts.

During an interview, the Executive Director (ED) confirmed that no action had been taken to ensure the RNs listed above had current certificates of registration with the College of Nurses of Ontario before performing the duties of a RN in the home.

b) Staff #607 accepted a position as a part time Registered Practical Nurse (RPN) in the home and worked their first shift in this position on an identified date in 2014. Staff # 607 continued to work in this position and worked 73 shifts performing the duties of a RPN. The clinical record confirmed that this staff person performed the duties of an RPN which included assessing resident's health conditions, administering medications and documenting in the clinical record.

Registered staff #601, staff #607 and records maintained by the home confirmed that while performing the duties of a RPN over the course of the 73 shifts worked in the home they did not hold a certificate of registration.
Registered staff # 601 confirmed that no action had been taken to ensure staff # 607 held a current certificate of registration with the College of Nurses of Ontario before performing the duties of a RPN in the home. [s. 46.]

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 and ensuring that very member of the staff who performs duties in the capacity of Registered Nurse or Registered Practical Nurse had the appropriate current certificate of registration with the College of Nurses of Ontario, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 73. Staff qualifications
Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,
(a) have the proper skills and qualifications to perform their duties; and
(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Findings/Faits saillants :

1. The licensee failed to ensure that all staff of the home had the proper skills and qualifications to perform their duties.
Staff # 607 was employed by the home as a Registered Practical Nurse (RPN) and worked in the home on a part time basis over a seven month period of time. During this period of time documents provided by the home confirmed staff # 607 worked 73 shifts in a position as a RPN and was paid at a rate of an RPN. On an identified date in 2015 staff # 607 confirmed to registered staff #601 that they did not hold a certificate of registration as a RPN from the College of Nurses of Ontario. At the time of this inspection, records provided by the home confirmed that the home did not take action to ensure staff #607 had the proper skills and qualifications to perform the duties of an RPN when they failed to obtain verification from a recognized training program that staff # 607 had successfully completed a RPN training program, failed to maintain records to verify that staff #607 had been evaluated related to skill performance during the initial "probationary" period of employment and failed to ensure this staff member held a certificate of registration as an RPN from the College of Nurses of Ontario. [s. 73.]

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 and ensuring that all staff of the home had the proper skills and qualifications to perform their duties, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 75. Screening measures

Findings/Faits saillants :

1. The licensee failed to ensure that screening measures including criminal reference checks were conducted in accordance with the regulations before hiring staff.

Registered Nurses (RNs) # 603, #604 and #605 worked at the long term care home as agency RNs, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request.

Registered nurses # 603, #604 and # 605 were identified as "staff" according to the interpretation of "staff" in the LTCHA, 2007, as a person who worked at the home, pursuant to a contract or agreement between the, licensee and an employment agency or other third party.

In accordance with LTCHA 2017, c. 8, s. 75(3) for the purpose of 75(1), a staff who works in the home pursuant to a contract between the licensee and an employment agency, is considered to be hired when they first work in the home.

In accordance with O. Reg.79/10. s. 234 (1) and (4) the licensee must keep a record of a staff's criminal reference check for any staff member that falls under clause (c) of the interpretation of staff.

During an interview on December 14, 2016, the Executive Director confirmed that they did not believe that actions were taken to ensure Registered Nurses # 603, # 604 and # 605 had criminal reference checks before they worked in the home and there were no records available in the home related to criminal reference checks for these three staff. [s. 75.]

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 and ensuring that screening measures including criminal reference checks were conducted in accordance with the regulations before hiring staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff at the home received training as required.

The licensee failed to ensure that all staff received training in the following areas before they perform their responsibilities:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2).

Registered Nurse (RN) # 603, #604 and # 605, who worked in the home, were identified as "staff" according to the interpretation of "staff" in the LTCHA, 2007, as a person who worked at the home, pursuant to a contract or agreement between the, licensee and an employment agency or other third party.

a) The Director of Care (DOC) and documentation provided by the home confirmed that RN #603 first performed their responsibilities in the home on an identified date in 2015.
-During an interview the Assistant Director of Care (ADOC) confirmed that part of their role was to be the lead for the training and orientation program in the home and they had held this position since May 30, 2015. The ADOC confirmed that they had not provided RN #603 with orientation to the home and that there was no documentation available to demonstrate that this staff person had received the mandatory training in the areas required before performing their responsibilities, specifically:
i. Resident's Bill of Rights,
ii. The long term care home's mission statement,
iii. The home's policy to promote zero tolerance of abuse and neglect of residents,
iv. The duty under section 24 to make mandatory reports,
v. The protection afforded by section 26,
vi. The home's policy to minimize the retraining of residents,
vii. Fire prevention and safety,
viii. Emergency evacuation procedures,

ix. Infection prevention and control,
x. The written procedures for handling complaints and the role of staff in dealing with complaints, safe and correct use of equipment, including; therapeutic equipment, mechanical lifts, assistive devices and positioning aids, as well as cleaning and sanitizing of equipment relevant to the staff members responsibilities, as required in O. Reg. 79/10 s. 218,
xi. Hand hygiene, modes of infection transmission, cleaning and disinfecting practices and use of personal protective equipment, as required in O. Reg. 79/10, s. 219 (4).

b) The DOC and documentation provided by the home confirmed that RN #604 first performed their responsibilities in the home on an identified date in 2016.
- The ADOC confirmed that they had not provided RN #604 with orientation to the home and that there was no documentation available to demonstrate that this staff person had received the mandatory training in the areas required before performing their responsibilities, specifically:
i. Resident's Bill of Rights,
ii. The long term care home's mission statement,
iii. The home's policy to promote zero tolerance of abuse and neglect of residents,
iv. The duty under section 24 to make mandatory reports,
v. The protection afforded by section 26,
vi. The home's policy to minimize the retraining of residents,
vii. Fire prevention and safety,
viii. Emergency evacuation procedures,
ix. Infection prevention and control,
x. The written procedures for handling complaints and the role of staff in dealing with complaints, safe and correct use of equipment, including; therapeutic equipment, mechanical lifts, assistive devices and positioning aids, as well as cleaning and sanitizing of equipment relevant to the staff members responsibilities, as required in O. Reg. 79/10 s. 218,
xi. Hand hygiene, modes of infection transmission, cleaning and disinfecting practices and use of personal protective equipment, as required in O. Reg. 79/10, s. 219 (4).

c) The DOC and documentation provided by the home confirmed that Registered Nurse #605 first performed their duties in the home on an identified date in 2016.
-The ADOC confirmed that they had not provided RN #604 with orientation to the home and that there was no documentation available to demonstrate that this staff

person had received the mandatory training in the areas required before performing their responsibilities, specifically:
i. Resident's Bill of Rights,
ii. The long term care home's mission statement,
iii. The home's policy to promote zero tolerance of abuse and neglect of residents,
iv. The duty under section 24 to make mandatory reports,
v. The protection afforded by section 26,
vi. The home's policy to minimize the retraining of residents,
vii. Fire prevention and safety,
viii. Emergency evacuation procedures,
ix. Infection prevention and control,
x. The written procedures for handling complaints and the role of staff in dealing with complaints, safe and correct use of equipment, including; therapeutic equipment, mechanical lifts, assistive devices and positioning aids, as well as cleaning and sanitizing of equipment relevant to the staff members responsibilities, as required in O. Reg. 79/10 s. 218,
xi. Hand hygiene, modes of infection transmission, cleaning and disinfecting practices and use of personal protective equipment, as required in O. Reg. 79/10, s. 219 (4).

The ADOC confirmed that the home follows a policy and procedure for orientation identified in the document "Orientation Program-Ontario". Following a review of this document the ADOC confirmed that the "Orientation Program-Ontario" indicated that "all new employees, including the Executive Director, Managers, frontline employees and student placement are referenced in the document, but the document does not speak specially about the orientation of staff who are working in the home pursuant to a contract or agreement between the licensee and an employment agency. The ADOC confirmed that to their knowledge the home did not have policies/practices for the orientation of staff working in the home pursuant to an agreement with an employment agency.
The licensee did not have policies, procedures or directions for the training and orientation of staff working in the home pursuant to a contract with an employment agency and RN #603, RN #604 and RN #605 did not receive training in the mandatory areas before performing their duties in the home. [s. 76. (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 an ensuring that training is provided in accordance with s. 76(1) and s. 76(2), to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one Registered Nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times.
Brierwood Gardens is a long term care home with a licensed capacity of 79 beds. The planned staffing pattern for registered nursing staff in the home, for the direct care of residents, was three Registered Nurses (RNs) for a total of 24 hours a day and four Registered Practical Nurses (RPNs) for a total of 32 hours a day, as identified on work schedules provided by the home and confirmed by the Executive Director (ED).
During an interview, the ED and the Director of Care (DOC) identified that the home did not have a sufficient number of Registered Nurses within the staffing plan to fill all the shifts related to staffing events such as sick calls. The DOC confirmed that the home consistently offered additional shifts to regular registered nurses to fill these vacant shifts; however, when the registered nurses employed by the home were unwilling or unable to work one or more of the required shifts the home would fill those shifts with registered nurses employed with an employment agency. On request the home provided a list of shifts over the most recent six month period of time which identified there were eight occasions (1.6% of total shifts worked over the period of time) where agency registered nurses worked to ensure that a registered nurse was on site 24 hours a day. The DOC confirmed that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).
The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as possible of an unexpected or sudden death, including a death resulting from an accident.
Resident #002 died unexpectedly on an identified date in 2015, and this death was not reported to the Director.
Resident #002’s clinical record indicated the resident had an unwitnessed fall on an identified dated in 2015, the resident demonstrated alterations in skin integrity as a result of the fall, the resident had no complaints of pain and was assisted into a sitting position by staff. Clinical documentation indicated staff continued to monitor the resident.
Documentation by staff did not indicate there were any concerns during monitoring of the resident in the immediate post fall period and in response to staff’s questions to determine if the resident was experiencing pain, the resident would usually respond “no”. An assessment completed and documented three days after the fall indicated that staff would be contacting resident #002's physician in relation to pain the resident was experiencing and three other care issues that did not relate to the fall incident.
The Physician assessed the resident five days following the fall incident and documented that “the resident complained of a headache initially but was much improved”. The Physician’s plan at this time was to monitor the resident and reduce a medication that the resident was taking. This note did not indicate that the resident's condition was poor and instead indicated the resident is much improved.The following day staff documented that the resident complained of feeling shaky, but all other aspects of an assessment of the resident's condition appeared to be within normal range for this resident. Later the same day staff documented that the resident's level of alertness had changed and they were continuing to monitor the resident through this period of time. Four hours later staff documented that the resident's condition had deteriorated and the resident was transferred to hospital for assessment and treatment.
Staff contacted the hospital for an update on resident #002's condition and were informed that the resident had passed away in hospital four hours after being admitted.

Registered staff # 601 confirmed that the home did not submit a Critical Incident System report or contact the Ministry to inform of sudden/unexpected death of resident #002. [s. 107. (1)]

Issued on this 31 day of August 2017 (A1)

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

Original report signed by the inspector.

Ontario

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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Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : PHYLLIS HILTZ-BONTJE (129) - (A1)

Inspection No. / No de l'inspection : 2016_205129_0015 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 029648-16 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Aug 31, 2017;(A1)

Licensee / Titulaire de permis : REVERA LONG TERM CARE INC.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000

LTC Home / Foyer de SLD : BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Debbie Boakes

Ontario

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

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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

(A1)
The licensee shall provide face to face training by October 6, 2017, to all registered staff who administer medication related to the standard of practice for medication administration. The licensee shall also develop and implement a schedule for monitoring the medication administration practices of the above noted staff as per the definition of "staff" identified in the Long Term Care Home Act, 2007, c. 8, s. 2 (1).

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

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Grounds / Motifs :

1. This Order was based on three factors: severity, scope and history of non-compliance in keeping with section 299(1) of Ont. Regulation 79/10. The severity was identified as 2 (minimal harm or potential for actual harm), the scope was identified as 1 (isolated) and the compliance history was identified as 4 (ongoing non-compliance with a VPC or CO) as a Compliance Order was issued on May 2, 2014 and a Voluntary Plan of Correction was issued on May 5, 2016.

2. Resident #001 was administered a drug that was not in accordance with the directions for use specified by the resident's physician. Resident #001's physician wrote an order on an identified date, to administer a specific drug, identified the specific dose of the drug to be administered and the time frequency in which the drug was to be administered. Documentation in the resident's plan of care, specifically the electronic progress notes indicated that registered staff #603, who worked in the home pursuant to a contract with an employment agency, administered two doses of the drug on an identified date and the time frequency between the two doses of the drug were not in accordance with the time frequency specified by the resident's physician. Registered staff #606 and medication administration records maintained by the home confirmed that the drug specifically provided for this resident indicated that the resident had received two doses of the drug within a time frequency that was not in accordance with the time frequency specified by the resident's physician. The licensee failed to ensure that resident #001 was administered a drug in accordance with the directions specified by the resident's physician.

(129)

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

Oct 06, 2017

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

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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

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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 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

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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.

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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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.

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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.

Issued on this 31 day of August 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE - (A1)

Service Area Office /
Bureau régional de services : Hamilton