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 6, 2022	
Inspection Number: 2022-1181-0001	
Inspection Type: Complaint Critical Incident System (CIS)	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Brierwood Gardens, Brantford	
Lead Inspector Lisa Bos (683)	**Inspector Digital Signature** Lisa Bos Digitally signed by Lisa Bos Date: 2022.12.07 12:33:08 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 21-24, 28-30, and December 1, 2022

The following intake(s) were inspected:

- Intake #00004428 (complaint) was related to the prevention of abuse and neglect, resident care and support services, housekeeping and maintenance and nutrition and hydration;
- Intake #00006989, CIS #2678-000017-22 was related to the prevention of abuse and neglect; and
- Intake #00005546, CIS #2678-000024-22 was related to transferring and positioning techniques.

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

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

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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)
FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that the written plan care set out the planned care for three residents related to their sleep patterns and preferences.

Rationale and Summary
A) A resident's written plan of care was reviewed, and there was a focus for sleep patterns and preferences, but the interventions were incomplete. It was blank under the time the resident preferred to be wakened and the time the resident preferred to go to sleep.

The resident's admission assessment indicated the time they preferred to wake and their preferred bedtime.

The Director of Care (DOC) acknowledged that the resident's preferred wake time and bedtime from the admission assessment did not populate to their plan of care, and that it should have included direction to staff regarding the resident's sleep patterns and preferences. The resident's plan of care was updated with their preferences.

Sources: A resident's clinical record; interview with the DOC and other staff.

Date Remedy Implemented: November 28, 2022
[683]

B) A resident's written plan of care was reviewed, and there was a focus for sleep patterns and preferences, but the interventions were incomplete. It was blank under the time the resident preferred to be wakened and the time the resident preferred to go to sleep.

The resident's admission assessment indicated the time that they preferred to wake, and they did not have a preferred bedtime.

The DOC acknowledged that the resident's preferred wake time and bedtime from the admission assessment did not populate to their plan of care, and that it should have included direction to staff regarding the resident's sleep patterns and preferences. The resident's plan of care was updated with their preferences.

Sources: A resident's clinical record; interview with the DOC and other staff.

Date Remedy Implemented: November 28, 2022
[683]

C) A resident's written plan of care was reviewed, and there was a focus for sleep patterns and preferences, but the interventions were incomplete. It was blank under the time the resident preferred to be wakened and the time the resident preferred to go to sleep.

The resident's admission assessment indicated the time that they preferred to wake and their preferred bedtime.

The DOC acknowledged that the resident's preferred wake time and bedtime from the admission assessment was not included in their plan of care, and that it should have included direction to staff regarding the resident's sleep patterns and preferences. The resident's plan of care was updated with their preferences.

Sources: A resident's clinical record; interview with the DOC and other staff.

Date Remedy Implemented: November 29, 2022
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NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary

A resident's written plan of care indicated under the focus that they required no support for transfers and under the interventions it stated that they required assistance for transfers.

A Personal Support Worker (PSW) and Registered Practical Nurse (RPN) reported that the resident required assistance with transfers.

The DOC acknowledged that the resident's written plan of care did not set out clear directions related to their transfer status. Their plan of care was updated to reflect the resident's current status.

Sources: A resident's clinical record; interview with a PSW, RPN, the DOC and other staff.

Date Remedy Implemented: November 28, 2022
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NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that resident that the written plans of care for two residents were reviewed and revised when care set out in the plan was no longer necessary.

Rationale and Summary
A) A resident's written plan of care indicated that they had an intervention in place for behaviours.

The resident's progress notes indicated that the intervention was discontinued. The DOC acknowledged that the resident no longer required the intervention and that their care plan was not revised when it was no longer necessary. The resident's care plan was updated to reflect their current status.

Sources: A resident's clinical record; interview with the DOC and other staff.

Date Remedy Implemented: November 28, 2022
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B) A resident's written plan of care indicated that they required a device, which was to be worn at all times, and a specified level of assistance with transfers.

Upon observation, the resident was not wearing the device, and staff were not providing the level of assistance with transfers as specified in their plan of care.

A RPN acknowledged that the resident no longer required the device and that they no longer required the level of assistance with transfers as specified in their plan of care. They acknowledged that their plan of care was not revised when the interventions were no longer necessary, and their plan of care was updated to reflect their current status.

There was no impact and no risk to the resident as staff were aware of their current transfer status and the device was no longer required.

Sources: A resident's clinical record; resident observations; interview with a RPN and other staff.

Date Remedy Implemented: November 24, 2022
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NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 19 (2) (a)

The licensee has failed to ensure that the curtains in a resident room were kept clean and sanitary.

Rationale and Summary
On two occasions, the curtains on the window in a resident room were observed with a brown liquid substance on them. A housekeeping staff member acknowledged that the curtains were dirty and stated that the spill must have been missed when the room was cleaned.

There was no impact and no risk to the residents and the curtains were cleaned.

Sources: Observations; interview with a housekeeping staff member.

Date Remedy Implemented: November 28, 2022
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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who had reasonable grounds to suspect improper or

incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident was immediately reported to the Director.

Rationale and Summary
The Resident Assessment Instrument (RAI)-Coordinator and the DOC were sent written communication regarding an area of skin impairment on a resident, where it was alleged that it may have been caused by improper or incompetent treatment or care.

A Critical Incident (CI) report was not submitted to the Director until 18 days later, when the concern was again brought forward.

The DOC indicated at the time of the inspection that they were unaware of the communication sent to the RAI-Coordinator and themselves and acknowledged that it should have been immediately reported to the Director when the concern was received.

Failing to immediately report improper or incompetent of a resident to the Director may have put residents at risk of harm.

Sources: A resident's clinical record; communication sent to the DOC and RAI-Coordinator; interview with the DOC.
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WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary
A PSW transferred a resident between two locations without a device in place, which resulted in an injury to the resident. According to the CI report, the PSW acknowledged that the device should have been in place at the time.

The home had a safety protocol that indicated the device must be used at all times for residents who required a specific mobility aid.

The DOC acknowledged that the device was required for all residents who used a mobility aid when they were being transferred between locations and that they should have been in place for the resident at the time of the incident.

A resident sustained an injury when a PSW failed to put a device in place when they transferred a resident between locations.

Sources: A Critical incident report; a resident's clinical record, Revera safety protocol document; interview with the DOC and other staff.
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