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 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 performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 9, 2013	2013_201167_0036	H-000723-13, H-000725-13	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

BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5

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

MARILYN TONE (167), LESLEY EDWARDS (506), MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 12, 13, 14, 15, 18, 19, 20, 21, 22, 2013

This inspection was completed related to Complaint Logs H-000432-13, H-000707 -13, H-000440-13, H-000725-13 and H-000723-13.
An area of non compliance LTCHA s. 6(10)b was issued related to this inspection on the follow up inspection H-000739-13/2013_201167_0034 conducted simultaneously with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Executive Director (ED), the Resident Assessment Instrument Coordinator (RAI Coordinator), the Registered Dietitian, the Resident Services Coordinator, registered staff, personal support workers, housekeeping staff, the Nutrition Manager, dietary aides, residents and family members.

During the course of the inspection, the inspector(s) conducted of a review of the health files for identified residents, reviewed relevant policies and procedures, observed care and meal service and conducted tours of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Medication
Personal Support Services
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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).

Findings/Faits saillants :

1. The licensee did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) On an identified date in 2013, the Executive Director (ED) received a call from the registered nurse in charge at the home indicating that the home's electronic Medication Administration System (eMAR) was not functioning.
B) The ED indicated that they told the registered nurse to notify the home's Information Technology Support and to call the emergency pharmacy number. The registered nurse at the home also indicated to the ED that the back up system for the eMARs was not working.
C) It was later noted that there was a systemic outage of the corporation's internet system. It was also noted that the registered nurse did not call the emergency pharmacy number as directed and it was confirmed that medications were not administered to residents on the day shift on the identified date.
D) During an interview conducted with the Director of Care, it was confirmed that the home does have a back up system for the eMAR system that does not require internet connection but the staff at the home did not appear to know how to access it. The DOC confirmed that the staff working on the identified date had received training related to this back up system. A review of the home's pharmacy manual confirmed that the manual did include a procedure for accessing a paper copy of the Medication Administration Records (MARs) and that the pharmacy manual was located at the nurses station.
E) The Director of Care at the home confirmed that they were not aware that the medication system was down until the next morning when they came in to work. [s. 131. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that that appropriate actions were taken in response to any medication incident involving a resident.

A) On an identified date in 2013, the home's electronic Medication Administration System (eMars) became non-functional resulting in residents at the home not receiving their prescribed medications for at least an eight hour period on the day shift.
B) A review of the documentation on the health files for residents at the home and interviews with the Director of Care and the Executive Director confirmed that at least 18 diabetic residents did not receive their prescribed insulin or oral hypoglycemics on the identified date, and there was no documentation to indicate that these residents were monitored for risk associated with this omission. There was no documentation to indicate that four residents with regular narcotic analgesia prescribed were monitored for pain and a number of other residents with regularly prescribed medications including but not limited to psychotropic medications, anti-hypertensives and inhalers and were monitored for risk associated with omission of the drug. [s. 134. (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a documented record was kept at the home of every written and verbal complaint that included all information required in s. 101(2).

The home's complaint policy directs staff to use the Client Services Response Form (CSR) to record information related to complaints. During a review of three complaints received at the home the following was noted.
A) Complaint # 1 was received on an identified date in 2013. A review of the home's CSR form related to the complaint confirmed that there was no documentation related to the type of action taken to resolve the complaint including the date of the action, time frames for action to be taken and any follow up actions required, the final resolution if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn to the complainant.
B) Complaint # 2 was received on an identified date in 2013. A review of the home's CSR form related to this complaint confirmed that there was no documentation related to the type of action taken to resolve the complaint including the date of the action, time frames for action to be taken and any follow up actions required, the final resolution if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn to the complainant.
C) Complaint # 3 was received at the home on an unidentified date in 2013. It was confirmed by the manager that received the complaint that no CSR form was initiated or completed related to this complaint. The identified manager indicated that the complaint was dealt with informally and no documentation was completed but confirmed that they should have completed a CSR form related to the complaint.
D) Three managers interviewed confirmed that they were aware of the need to complete the CSR form for all complaints received and to follow the process identified in the home's policy related to documentation of complaints. During an interview with the home's Executive Director, it was confirmed that the three CSR forms were not completed as required. [s. 101. (2)]

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 to ensure that there is a documented record of every written and verbal complaint that includes all required information as directed in r.101(2), to be implemented voluntarily.

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 10th day of December, 2013

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

Marilyn Love

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARILYN TONE (167), LESLEY EDWARDS (506), MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2013_201167_0036
Log No. / Registre no:	H-000723-13, H-000725-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 9, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
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 :	CATHERINE DONAHUE

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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:

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

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 :

The licensee shall prepare, implement and submit a plan to ensure that all registered staff at the home receive training and are competent in the use of the back up system for the electronic medication administration system at the home.

The plan shall include training of staff related to the processes to follow when the system is non- functional including demonstration of competence in the use of the back up system and clear direction related to notification of appropriate persons and follow up when incidents occur.

The plan shall be submitted electronically to Marilyn Tone at: Marilyn.Tone@ontario.ca by December 30, 2013.

Grounds / Motifs :

1. The licensee did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) On an identified date in 2013, the Executive Director (ED) received a call from the registered nurse in charge at the home indicating that the home's electronic medication administration system (eMAR) was not functioning.
B) The ED indicated that they told the registered nurse to notify the home's Information Technology Support and to call the emergency pharmacy number. The registered nurse at the home also indicated to the ED that the back up system for the eMARs was not working.
C) It was later noted that there was a systemic outage of the corporation's internet system. It was also noted that the registered nurse did not call the emergency pharmacy number as directed and it was confirmed that medications were not administered to residents as prescribed on the identified date.
D) During an interview conducted with the Director of Care, it was confirmed that the home does have a back up system for the eMAR system that does not require internet connection but the staff at the home did not appear to know how to access it. The DOC confirmed that the registered staff working on the identified date had received training related to this back up system. A review of the home's pharmacy manual confirmed that the manual did include a procedure for accessing a paper copy of the Medication Administration Records (MARs) and that the pharmacy manual was located at the nurses station.
E) The Director of Care at the home confirmed that they were not aware that the medication system was down until the next morning when they came in to work. (167)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee shall prepare, implement and submit a plan to ensure that appropriate action is taken related to assessment and monitoring of residents when medication incidents occur.

The plan shall be submitted electronically to Long Term Care Homes Inspector, Marilyn Tone at Marilyn.Tone@ontario.ca by December 30, 2013

Grounds / Motifs :

1. The licensee did not ensure that that appropriate actions were taken in response to any medication incident involving a resident.

A) On an identified date in 2013, the home's electronic medication administration system (eMars) became non-functional resulting in residents at the home not receiving their prescribed medications for at least an eight hour period on the day shift.
B) A review of the documentation on the health files for residents at the home and interviews with the Director of Care and the Executive Director confirmed that at least 18 diabetic residents did not receive their prescribed insulin or oral hypoglycemics on the identified date and there was no documentation to indicate that these residents were monitored for risk associated with this omission. There was no documentation to indicate that four residents with regular narcotic analgesia prescribed were monitored for pain and a number of other residents with regularly prescribed medications including but not limited to psychotropic medications, anti-hypertensives and inhalers and were monitored for risk associated with omission of the drug. (167)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2014

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
Performance Improvement and Compliance 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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 9th day of December, 2013

Signature of Inspector / Signature de l'inspecteur : Marilyn Tone

Name of Inspector / Nom de l'inspecteur : MARILYN TONE

Service Area Office / Bureau régional de services : Hamilton Service Area Office