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

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 2, 2016	2016_275536_0009	012363-16	Resident Quality Inspection

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

CATHIE ROBITAILLE (536), CAROL POLCZ (156), LESLEY EDWARDS (506), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 5, 6, 9, 10, 11, 12, 13, 16 and 17, 2016.

The following inspections were completed concurrently with the RQI:

Complaints
034523-15-Hospitalization and change in condition, pain, continence and

prevention of abuse and neglect
007971-16-Nutrition and hydration and falls prevention

Critical Incident System Reports

004318-15-Falls prevention
004944-15-Falls prevention
022751-15-Responsive behaviours
024402-15-Falls prevention
036181-15-Personal support services and pain

Follow-up Inspections

009266-15- FU to 2015-265528-0010 (H-001829-15) CO #001–Reg. 8.(1) b, HSAO Log # H-002474-15
009267-15- FU to 2015-265528-0010 (H-001829-15) CO #002 S 6(1) (4) (7) (11), HSAO Log# H-002475-15
009268-15- FU to 2015_267528_0010 (H-001829-15) CO #003- S 6(7) Intake # 009268 -15, H-003232-15

During the course of the inspection, the inspector(s) spoke with the Executive Director, Administration Assistant, Business Manager, Director of Care (DOC), Assistant Director of Care/Staff Educator (ADOC), Resident Assessment Instrument Material Data Set(RAI) Co-Ordinator, Behavioural Support Ontario (BSO), Environmental Service Manager (ESM), Business Manager, Corporate Consultant, Registered Dietician (RD), registered staff, personal support workers (PSW's), restorative care aide, ward clerk, dietary aides, housekeeping staff, Nutrition Manager (NM), Registered Dietitian (RD), residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents including but not limited to: menus, staffing schedules, policies and procedures, meeting minutes, clinical health records, and investigation reports.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #002	2015_267528_0010	536
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #003	2015_267528_0010	536
O.Reg 79/10 s. 8. (1)	CO #001	2015_267528_0010	506

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #008 was transferred using safe transferring and positioning techniques.

On an identified date, resident #021 was assisted using a mechanical lift with two staff members. Personal Support Worker (PSW) #104 confirmed that the resident was not positioned properly while using the lift. The resident immediately said to the staff that an identified area hurt. Once the PSW's settled the resident into the bed, the resident asked for a pain pill. The physician was in shortly after the incident, and ordered an x-ray of the area. The x-ray was completed the following day, and it was confirmed that the resident sustained an injury and was sent to the hospital. PSW #103 who is in charge of the home's safe lifting program, reviewed the incident with the PSW's involved and confirmed, that the staff did not follow safe transferring and positioning techniques with the resident as per the residents plan of care. [s. 36.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Resident #047 was noted to have had an un-witnessed fall on an identified date in 2015, which did not result in injury. The resident had been left unattended as confirmed by progress notes, fall assessment and critical incident system (CIS) report submitted to the Ministry of Health and Long Term Care (MOHLTC). The plan of care in place at the time of the fall for resident #047, indicated that the resident was not to be left unattended. The care set out in the plan of care was not provided to the resident, as specified in the plan. This was confirmed by the Director of Care (DOC). [s. 6. (7)]

2. The licensee has failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

Resident #021 sustained an injury on an identified date in 2015. The home submitted a critical incident system (CIS) report to the Director that identified that the resident's plan of care would be updated to reflect specific transferring and positioning techniques due to the resident's diagnosis. A review of the resident's plan of care did not include the interventions as outlined in the CIS. The Director of Care (DOC)confirmed, that the resident's plan of care was not reviewed and revised, to include specific transferring and positioning techniques that were identified. [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 care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The home's "Abuse and Neglect" policy LP-C-20-ON, last revised: September 2014, indicated that:

A) Any staff member or person who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the home or, if unavailable, to the most senior supervisor on the shift at that time.
B) Mandatory reporting under the "Long Term Care Homes Act, 2007": section 24(1) of the LTCHA, requires any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, shall immediately report the suspicion and the information upon which it was based to the Director of Long Term Care homes: abuse of a resident by anyone, or neglect of a resident by the licensee or staff member that resulted in harm or a risk of harm to the resident.
C) The resident's Substitute Decision Maker (SDM) will be notified immediately upon the home becoming aware of any alleged, suspected or witnessed abuse.

According to the progress notes, resident #004 was involved in an interaction with co-resident #022 on an identified date in 2015. The incident as detailed in the progress notes suggested that there were reasonable grounds to suspect abuse to co-resident #022. The Director of Care (DOC) confirmed that the incident was not reported to the Director as required.

A review of resident #022's clinical record did not include that the home had notified the Substitute Decision Maker (SDM) regarding the alleged abuse. Interview with the DOC confirmed that the SDM was not notified. [s. 20. (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 and ensuring that the abuse policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions are documented.

A) The homes program/policy "Fall Interventions Risk Management" indicated that when a fall was not witnessed or the resident had hit their head, a neurological assessment will be initiated and the resident will be monitored for 72 hours. Further, for all falls, a complete clinical assessment will be completed and documented including vital signs every shift for a minimum of 72 hours. The post fall documentation is in the interdisciplinary progress notes.

i) Resident #045 was noted to have had a witnessed fall on an identified date. A post fall progress note was not completed by the day, evening and night shifts, or the day and evening shifts on identified dates. This was confirmed by the Director of Care (DOC).
ii) Resident #045 was noted to have had a witnessed fall on an identified date. A post fall progress note was not completed by the day shift on an identified date. This was confirmed by the DOC.

iii) Resident #045 was noted to have had an un-witnessed fall on an identified date. A post fall progress note was not completed by the day shift or the evening shift on an identified date. This was confirmed by the DOC.
iv) Resident #047 was noted to have had an un-witnessed fall on an identified date in 2015. A post fall clinical assessment was not documented in the progress notes, by the evening shift on an identified date in 2015. This was confirmed by the DOC. (156)

B) Resident #045 had identified individual physician orders. The Medication Administration Records (MARS) and Physicians Orders Audit Report were reviewed. The DOC confirmed there were twenty one different times, where the actions were not documented that they occurred. (156)

C) The Home's program/policy "Pain Assessment and Symptom Management", directed the nurse to review Minimum Data Set (MDS)assessment related to pain (sections J2 and J3), and review the residents outcomes. The Resident Assessment Protocols (RAP's) will be completed to determine the need for additional pain assessment and monitoring and/or additional referral. The program/policy further identified that: if the resident complains of pain, a quick pain assessment on the resident will be completed and documented. The resident's pain will be measured using a standardized, evidenced-informed clinical tool and that staff will initiate a pain monitoring tool when as needed (PRN) medication is used for 3 consecutive days and that staff will initiate a pain monitoring tool when a new regular pain medication is ordered.

Resident #021 had a newly identified injury on an identified date, which resulted in a transfer to the hospital and increase in pain and as needed (PRN) analgesic use. The clinical record did not include a completed pain assessment with the reports of newly identified pain. A review of the Medication Administration Records (MAR) and progress notes identified that the resident consecutively used PRN analgesic on identified dates in 2016. The clinical record did show an incomplete pain monitoring tool, which stated "pain monitoring incomplete, please chart every shift, as resident has been given PRN analgesic for an identified number of days". This was confirmed by the Resident Assessment Instrument (RAI) Co-ordinator, during a record review. The RAI Co-ordinator confirmed the program expectations for the completion of a pain assessment and pain monitoring tools; however, confirmed that these would be maintained in the resident's record, if completed. (506)

D) The home's records were reviewed including the Fall Risk Assessment Tool (FRAT) program/policy and it stated: a Fall Risk Assessment must be completed for all residents

with initial assessment and every four months thereafter.

The record of resident #031 who had a fall on an identified date that resulted in a significant change in their health status was reviewed. Completed FRAT's were located in the resident's record. There were no completed FRATs for an identified period of time found in the resident's record.

The DOC was interviewed and reported that additional completed FRATs were not available. The DOC also confirmed that it was the home's expectations that the FRAT be completed for all residents at admission, and every four months thereafter and that this was not done for resident #031. (123)

The licensee has failed to ensure that any actions taken with respect to a resident under a program were documented. [s. 30. (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 and ensuring that any actions taken with respect to a resident under a program is documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents demonstrating responsive behaviours have strategies developed and implemented to respond to these behaviours.

Resident #046 was heard screaming, and appeared to be in distress. Resident #046 had known responsive behaviours, and had been seen previously by Behaviour Supports Ontario (BSO) for responsive behaviours for an identified activity of daily living (ADL). The document that the home refers to as the care plan, stated that BSO attended scheduled ADL's to assist with strategies to complete the task for the resident. BSO suggested on an identified date in 2015, that the home continue with strategies in place, and if the resident was verbally or physically responsive, then assist the resident back to their room and re-approach at a later time. When asked why the strategy from BSO was not implemented, PSW #106 confirmed, that the resident is always this way. The Director of Care (DOC) was asked to come and witness the incident by inspector #156, and confirmed that the resident was in distress and that the staff should have stopped the identified ADL. The home had developed strategies to help manage the resident's responsive behaviours but did not implement the strategies that were put in place to assist with managing the resident's responsive behaviours. [s. 53. (4) (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 demonstrating responsive behaviours that strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status

A) Resident #006 was observed asleep and not eating at the dining table during the lunch observation on an identified date. The resident was noted to have weights changes on identified dates in 2015 and 2016. According to the clinical record, the Registered Dietitian (RD) requested a reweigh on an identified date. The resident was re-weighed which resulted in a weight loss of 6.0 kg (9.0%) over three months or 7.0 kg (10.0%) loss over six months.

An interview with the DOC confirmed, that the expectation of the home would be for the RD to assess the weight loss on the next visit. The weight changes of over 7.5% and 10.0% were not assessed using an interdisciplinary approach, and actions were not taken and outcomes evaluated.

B) Resident #042 was noted to have weights completed on identified dates in 2016. The recorded weight on an identified date represented a 5.3 kg weight change (6.8 %) when compared to the previous month. The resident's quarterly nutrition assessment was completed by the Food Service Manager (FSM) on an identified date; however, there was no mention of the weight change, and the resident has not been assessed by the RD. The significant weight change was not evaluated by the RD as confirmed by the DOC. The weight change of over five per cent of body weight in one month, was not assessed using an interdisciplinary approach, and actions were taken and outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 weight changes are assessed and that actions taken and outcomes are evaluated, to be implemented voluntarily.

WN #7: 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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #045 had identified individual physicians orders for specific medications and interventions. The physicians orders identified specific times of day when the medication and the interventions were to be completed. Observation of registered staff #105 identified that the registered staff administered the medication over two hours late. This was confirmed by registered staff #105. The registered staff reported that usually the medication order and the interventions were completed at the same time as opposed to their identified times. The Director of Care (DOC) confirmed that the two individual physicians orders should be completed separately as ordered by the physician and that this intervention was not following the physicians order. [s. 131. (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 and ensuring that drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participates in the implementation of the infection prevention and control program.

i. On May 5, 2016, during the initial tour of the home, in an identified area unlabelled deodorant sticks and unlabelled hair combs, were observed with hair in them, as well as an unlabelled hairbrush, which also had hair in it.
ii.On May 5, 2016, during the initial tour of the home, in another identified area ,used and unlabelled hair combs with hair in them were observed, as well as a used and unlabelled container of vita-rub.

The DOC confirmed that these items are to be labelled to ensure they are used only on one resident. [s. 229. (4)]

2. The licensee has failed to ensure that all residents were offered immunization against pneumococcus, tetanus and diphtheria in accordance with publicly funded immunization schedules.

A) A review of the immunization documentation for resident #024, #025, #026 and #027 identified that these residents were not offered immunization against tetanus and diphtheria. The Assistant Director of Care (ADOC) confirmed that the home is to offer the tetanus and diphtheria vaccine as required to new residents or existing residents. The ADOC also confirmed, that these residents were not offered their tetanus and diphtheria vaccinations, in accordance with the publicly funded immunization schedule.

B) A review of the immunization documentation for resident #023, #024 and #027 identified that these residents were not offered their immunization against pneumococcus. The ADOC confirmed that these residents have not been offered their pneumococcal vaccination, in accordance with publicly funded immunization schedule. [s. 229. (10) 3.]

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 participate in the infection prevention and control program as well as, the immunization program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the programs included height upon admission and annually thereafter.

A) Resident #043 was noted to have their height last taken and recorded in 2014.
B) Resident #044 was noted to have their height last taken and recorded in 2014.

There were no annual heights taken for these residents for 2015, as confirmed with the Director of Care (DOC). [s. 68. (2) (e) (ii)]

WN #10: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,

ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident no later than one business day after the occurrence of the incident, followed by a report for an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Resident #021 sustained an injury at the home on an identified date in 2015, and was transferred to the hospital and admitted with an identified injury the following day. The Director was not notified of the incident until six days later, according to the critical incident system (CIS) report. This was confirmed by the Director of Care (DOC). [s. 107. (3) 1.]

2. The licensee has failed to ensure that the Director was informed when an amendment was requested.

A review of a critical incident system (CIS)report dated in 2015, identified that an amendment was requested. The Director of Care (DOC) confirmed, that the request by the Director for specific actions that have since been implemented to prevent re-occurrence and mitigate future risk was not submitted.

A review of a CIS report dated in 2015, identified that an amendment was requested. The Director of Care (DOC) confirmed, that the request by the Director for the outcome of the investigation and actions planned to prevent re-occurrence was not submitted. [s. 107. (4)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's written records were kept up to date at all times.

Resident #020 had a fall and sustained an injury, and was sent to the hospital for assessment on an identified date in 2015.

i.Resident #020 sustained a fall and was put on routine checks. It was documented that the resident was on these checks, but the checklist could not be found in the resident's clinical record.
ii. On another identified date, the hospital called to say resident #020 had passed away.

Review of the resident's plan of care did not include any of the above information. Interview with the DOC confirmed that this information should have been documented in the resident's clinical file. [s. 231. (a)]

Issued on this 2nd day of June, 2016

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHIE ROBITAILLE (536), CAROL POLCZ (156), LESLEY EDWARDS (506), MELODY GRAY (123)
Inspection No. / No de l'inspection :	2016_275536_0009
Log No. / Registre no:	012363-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 2, 2016
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 :	Debbie Boakes

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall complete the following:

1. Ensure all direct care staff are trained in proper use of mechanical lifts mitigating the risk when transferring and positioning residents.
2. A schedule for ongoing monitoring for residents who have specific instructions per lifting and transferring that these instructions are followed and documented.

Grounds / Motifs :

1. The order is made up on the application of the factors of severity (3), scope (1), and compliance history (3), in keeping with r. 36 of the Regulation, in respect to the actual harm for resident #021, the scope of this being an isolated issue in the home, and the licensee's history of non-compliance with a VPC issued in June 2013 and February 2014 during Critical Incident System (CIS) Inspections for r. 36.

The licensee has failed to ensure that resident #008 was transferred using safe transferring and positioning techniques.

On an identified date, resident #021 was assisted using a mechanical lift with two staff members. Personal Support Worker (PSW) #104 confirmed that the resident was not positioned properly while using the lift. The resident immediately said to the staff that an identified area hurt. Once the PSW's settled the resident into the bed, the resident asked for a pain pill. The physician was in shortly after the incident, and ordered an x-ray of the area. The x-ray was completed the following day, and it was confirmed that the resident sustained an injury and was sent to the hospital. PSW #103 who is in charge of the home's safe lifting program, reviewed the incident with the PSW's involved and confirmed, that the staff did not follow safe transferring and positioning techniques with the resident as per the residents plan of care. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 02, 2016

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

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
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.

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
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 2nd day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathie Robitaille

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