Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 24, 2020	2020_803748_0001	018433-19, 019393-19, 019821-19, 022702-19, 022756-19, 022834-19, 023588-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

EMMY HARTMANN (748)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 2, 6, 7, 8, 9, 10, 2020.

The following intakes were completed in this Critical Incident Inspection:

Log #019393-19, CIS #2678-000038-19, was related to resident to resident abuse.
Log #019821-19, CIS #2678-000040-19, was related to resident to resident abuse.
Log #022702-19, CIS #2678-000046-19, was related to resident to resident abuse.
Log #018433-19, CIS #2678-000037-19, was related to resident to resident abuse.
Log #022756-19, CIS #2678-000047-19, was related to resident to resident abuse.
Log #022834-19, CIS #2678-000048-19, was related to resident to resident abuse.
Log #023588-19, CIS #2678-000052-19, was related to resident to resident responsive behaviours.

During the course of the inspection, the inspector(s) spoke with residents, the Executive Director, Acting Director of Care, Assistant Director of Care (ADOC), Behavioural Support of Ontario (BSO) Lead, Pinkerton Agency Staff, housekeepers, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 WN(s)
2 VPC(s)
0 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, 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 was reassessed and the plan of care reviewed and revised when resident #003's care needs changed.

Log #022702-19, CIS #2678-000046-19, was an incident that was reported to the Ministry of Long Term Care (MLTC) related to resident#003's aggression towards resident #004.

A review of resident #003's plan of care identified that the resident had responsive behaviours. Resident #003's progress notes identified that there were three incidents of aggression by resident #003 towards other residents, on the identified dates.

A review of resident #003's progress notes documented on an identified date and time, indicated that there was an altercation between resident #003 and resident #004. Following this incident, the progress note indicated that the manager on-call was notified, and that they suggested for monitoring, to be initiated, for the following night shift and day shift.

Progress notes documented on an identified date and time, by RPN #107, identified that the monitoring was continuing and there were no concerns all shift. A review of resident #003's progress notes documented on an identified date and time, by RPN #107, identified that resident #003 was involved in an another altercation, and this time it was with resident #009.

Interview with RPN #107 verified that they worked on an identified date and time. They identified that resident #003's monitoring had changed. They identified that there was no monitoring being conducted when the altercation between resident #003, and resident #009 took place. RPN #107 identified that they were not aware that the monitoring was changed, and indicated that usually the monitoring was reassessed by management prior to discontinuation. RPN #107 identified that there was no reassessment of the risk at the end of the shift, to determine what the plan of care would be for resident #003 moving forward.

During an interview with the ADOC, they identified that they expected the nurse to complete a reassessment of resident #003, to determine the plan of care moving forward, and that this reassessment should have been completed before resident #003's monitoring was changed. During an interview with the Acting DOC, they acknowledged that there was no reassessment of the resident's risk or need for monitoring, prior to their monitoring being changed.

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when resident #009's care needs changed, related to responsive behaviour triggers.

A review of resident #009's clinical records identified that they had a cognitive impairment.

A review of resident #009's progress notes identified that an altercation took place between resident #003 and resident #009, on an identified date and time.

Interview with RPN #107 identified that they were the nurse that responded to the altercation between resident #009 and resident #003 on an identified date and time, and that they had identified triggers related to the altercation, but they did not add the triggers to resident #009 and resident #003's respective care plans.

The home's "Responsive Behaviour Rounds Procedure CARE3-010.05", last modified March 31, 2019, stated that an interdisciplinary responsive behaviour rounds were held to review any resident with a new or worsening, physically, sexually, or verbally threatening responsive behaviour, and any resident on one to one monitoring. It also indicated that someone would be appointed to update the resident care plan, and that the care plan would be updated to reflect any changes or updates.

A review of the minutes of meeting for the home's interdisciplinary clinical rounds identified that resident #009 was discussed on an identified date, and the minutes indicated resident #009's triggers.

A review of resident #009's written plan of care identified that the trigger to the altercation with resident #003, and the trigger identified in the home's interdisciplinary clinical rounds, were missing in the resident's plan of care.

During an interview with the ADOC, they confirmed that the written plan of care for resident #009, was not updated to include the trigger for the altercation with resident #003 on an identified date; and the trigger identified during the clinical rounds on an identified date.

During an interview with the Acting DOC, they acknowledged that the written plan of care for resident #009 should have been updated to include the triggers identified for resident #009.

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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

Log #022702-19, CIS #2678-000046-19, was an incident that was reported to the MLTC related to resident #003's responsive behaviour towards resident #004.

A review of resident #003's clinical records identified that they had a cognitive impairment.

A review of resident #003's progress notes identified that there was a history of altercations between resident #003 and other residents. On an identified date and time, it was documented by RPN #107, that an altercation took place between resident #003 and resident #009.

Interview with RPN #107 identified that they were the nurse that responded to the altercation between resident #009 and resident #003 on an identified date and time, and that they had identified triggers related to the altercation, but they did not add the triggers to resident #009 and resident #003's respective care plans.

The home's "Responsive Behaviour Rounds Procedure CARE3-010.05", last modified March 31, 2019, stated that an interdisciplinary responsive behaviour rounds were held to review any resident with a new or worsening, physically, sexually, or verbally threatening responsive behaviour, and any resident on one to one monitoring. It also indicated that someone would be appointed to update the resident care plan, and that the care plan would be updated to reflect any changes or updates.

A review of the minutes of meeting for the home's interdisciplinary clinical rounds identified that resident #003 was discussed on an identified date, and the triggers for the resident's behaviours were identified.

A review of resident #003's written plan of care identified that there were several triggers to their behaviours, and that not all of the triggers had all the identified interventions in place.

During an interview with the ADOC, they confirmed that resident #003's written plan of care did not include all identified interventions for resident #003.

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 steps are taken to minimize the risk of altercation and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

Issued on this 19th day of February, 2020

[redacted]

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

Original report signed by the inspector.