Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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	2019_803748_0016	017925-19, 018751-19	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): December 31, 2019, January 2, 6, 7, 8, 9, 10, 2020.

The following intakes were completed in this Complaint Inspection:

Log #018751-19 was a complaint related to staff to resident abuse.

The following Critical Incident System intake related to the same issue was also completed during this Complaint Inspection:

Log #017925-19, CIS #2678-000035-19 was related to staff to resident abuse.

This inspection was completed concurrently with Critical Incident Inspection #2020_803748_0001.

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.

- **1 WN(s)**
- **1 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 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 failed to ensure that behavioural triggers were identified for resident #001.

Log #017925-19, CIS #2678-000035-19, was an incident reported to the Ministry of Long Term Care (MOLTC) related to staff to resident abuse. Log #018751-19 was a complaint reported to the MOLTC related to staff to resident abuse.

A review of the home's investigation notes identified that the home conducted an investigation into a potential abuse of resident #001, by PSW #106. The home's investigation notes identified that PSW #106 indicated that resident #001 had behaviours during care.

Review of resident #001's records, identified that the resident had a cognitive impairment, and that the resident had several behaviours but that there were no potential triggers identified for their behaviours.

Interview with PSW #102 identified that they were familiar with the care of resident #001, and that they were mostly successful in providing care to the resident. PSW #102 identified that the resident exhibited behaviours during care, and identified triggers to the resident's behaviours.

Interview with PSW #103 identified that they had provided care for resident #001, and they identified triggers to resident's behaviours.

During an interview with RPN #107, resident #001's records were reviewed together with the inspector, and it was confirmed that potential behavioural triggers were not included in resident #001's responsive behaviour plan of care, as identified by several staff members.

During an interview with the ADOC, they identified that it was an expectation that potential behavioural triggers were added to a responsive behaviour plan of care, and that resident #001 should have had their potential behavioural triggers included in their care plan. [s. 53. (4) (a)]

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, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible, to be implemented voluntarily.

Issued on this 19th day of February, 2020

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

Original report signed by the inspector.