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

London District
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Original Public Report

Report Issue Date: August 10, 2023	
Inspection Number: 2023-1181-0003	
Inspection Type: Critical Incident System	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Brierwood Gardens, Brantford	
Lead Inspector Christie Birch (740898)	**Inspector Digital Signature** Christie Birch Digitally signed by Christie Birch Date: 2023.08.11 11:19:07 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 28, 31, 2023 and August 1, 2, 2023

The following intake(s) were inspected:

- Intake: #00091766 -[2678-000020-23] - related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that their Resident Non-Abuse Program policy and procedure titled, Investigations of Abuse or Neglect, was complied with.

Rationale and Summary

The home submitted a Critical Incident System report, reporting alleged abuse of a resident by a staff member.

The home's policy stated "The priority is to ensure the safety and comfort of the abuse victims by taking steps to provide for their immediate safety and well being, then completed full assessments to determine the Resident's needs and document them on the Resident's plan of care."

No completed assessment was evident of the resident at the time of the reported concern by the family in relation to alleged abuse to the resident.
During an interview with a member of the management of the home, they stated that they would expect an assessment of the resident to be done at the time of the reported concern as part of the investigation. They also stated they were not aware of whether an assessment was done, and were unable to locate one.

Sources: CIS, review of resident clinical records, investigation notes, interview with staff.
[740898]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee failed to ensure that a resident who sustained a skin tear was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A resident's family member reported alleged abuse to the management of the home which resulted in an injury. The resident sustained a skin tear.

The home's procedure stated "Re-Evaluation of the Skin Impairments /Wounds: Nurses are responsible

to monitor and reassess the wounds /skin impairment for progress on a regular basis and at dressing change. Document re-evaluation and wound progress weekly by using skin and wound app."

In an interview with the leaders at the home, they confirmed that the expectation with this injury would be daily monitoring on the electronic treatment record (ETAR) and a weekly skin assessment completed in Point Click Care (PCC). The leader acknowledged that the skin assessments were not done as expected.

In review of the PCC records and paper file of this resident, no daily monitoring was completed in the ETAR and no weekly skin assessments were completed.

Sources: Interview with staff, review of CI, PCC progress notes, careplan, assessments, Procedure Skin and Wound Re-evaluation
[740898]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee failed to ensure that the strategies that were developed for a resident 's responsive behaviours were implemented in response to those behaviours.

Rationale and Summary

The home submitted Critical Incident System report (CIS),reporting alleged abuse of a resident by staff. The staff member was attempting to provide personal care to a resident who displayed responsive behaviours. There were interventions documented for this behaviour but not implemented at the time of the incident.

Sources : record review of the investigation notes, resident care plan and kardex, interview with staff.
[740898]

WRITTEN NOTIFICATION: Notification Re Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)

The licensee failed to ensure that a resident's substitute decision-maker was notified of the results of the home's investigation of alleged abuse, immediately upon the completion of the investigation.

Rationale and Summary

A family member of a resident reported to a member of the management team, a concern of alleged abuse to a resident.

The allegation was investigated and the home did not call the family member with the results immediately upon completion of the investigation.

Sources: Critical Incident document, progress notes, investigation notes, interview with staff. [740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the response provided to a resident's family member, who made a complaint, included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary

A family member of resident, reported a concern related to the care of a resident, to a member of the management team.

The home did not give the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman, to the family member.

In an interview, the family member confirmed they were not given the Ministry's toll-free telephone number for making complaints about homes or the patient ombudsman contact information by anyone at the home.

Sources: Interview with staff and family member of resident, record review of investigation notes, progress notes and Critical Incident.
[740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee failed to ensure that a documented record was kept of the verbal complaint from a family member related to alleged abuse, including the nature of the complaint.

Rationale and Summary

A family member reported a concern of alleged abuse to a resident, to a member of the management team.

The home confirmed they did not keep a documented record of this complaint.

The complaint log did not contain any information related to this complaint.

Sources: Interview with staff, record review of investigation notes, progress notes and Critical Incident.
[740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (b)

The licensee failed to ensure that a documented record was kept of the verbal complaint from a family member related to alleged abuse, including the date the complaint was received.

Rationale and Summary

A family member of a resident, reported a concern of alleged abuse to a resident, to a member of the management team.

The home confirmed they did not keep a documented record of this complaint including the date the

complaint was received.

The complaint log did not contain any information related to this complaint.

Sources: Interview with staff, record review of investigation notes, complaint log, progress notes and Critical Incident.
[740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

The licensee failed to ensure that a documented record was kept of the verbal complaint from a family member to a member of the management team, related to alleged abuse, included the date of the action, time frames for actions to be taken and any follow-up action required.

Rationale and Summary

A family member of a resident reported a concern of alleged abuse to a resident, to a member of the management team.

The home confirmed they did not keep a documented record of this complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

The complaint log did not contain any information related to this complaint.

Sources: Interview with staff, record review of investigation notes, complaint log, progress notes and Critical Incident.
[740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)

The licensee failed to ensure that a documented record was kept of the verbal complaint from a family member related to alleged abuse, to a member of the management team, including the final resolution, if any.

Rationale and Summary

A family member of a resident reported a concern of alleged abuse to a resident, to a member of the management team.

The home confirmed they did not keep a documented record of this complaint, including the final resolution.

The complaint log did not contain any information related to this complaint.

Sources: Interview with staff, record review of investigation notes, complaint log, progress notes and Critical Incident.
[740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)

The licensee failed to ensure that a documented record was kept of the verbal complaint from a family member to a member of the management team, related to alleged abuse, including every date on which any response was provided to the complainant and a description of the response.

Rationale and Summary

A family member of a resident reported a concern of alleged abuse to a resident, to a member of the management team.

The home confirmed they did not keep a documented record of this complaint or any response to the complainant.
The complaint log did not contain any information related to this complaint.

Sources: Interview with staff, record review of investigation notes, complaint log, progress notes and Critical Incident.
[740898]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (f)

The licensee failed to ensure that a documented record was kept of the verbal complaint from a family member related to alleged abuse that included any response made in turn by the complainant.

Rationale and Summary

A family member of a resident reported a concern of alleged abuse to a resident to a member of the management team.

The home confirmed that they did not keep a documented record of this complaint or any response from the complainant.

The complaint log did not contain any information related to this complaint.

Sources: Interview with staff, record review of investigation notes, complaint log, progress notes and Critical Incident.
[740898]