Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: February 15, 2024	
Inspection Number: 2024-1181-0001	
Inspection Type: Complaint	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Brierwood Gardens, Brantford	
Lead Inspector Christie Birch (740898)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 6, 7, 8, 9, 2024

The following intake(s) were inspected:

- Complaint related to resident care.

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

Resident Care and Support Services
Infection Prevention and Control

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that a resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A complaint was received by the Director, related to care concerns.

The resident's care plan indicated that an intervention was in place. No documentation of consent or involvement with the resident's substitute decision maker (SDM) was noted prior to this intervention being put in place.
The Director of Care (DOC) confirmed that the intervention was being used without involvement or consent from the SDM and should have been done prior to it's use.

There was risk related to the lack of involvement of the resident's SDM in relation to an intervention in the plan of care.

Sources: Resident's clinical records; Homes policy; Interviews with staff.
[740898]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that an intervention was in place as specified in the plan of care

Rationale and Summary

The care plan of the resident specified an intervention to be used. During the inspection, observations were made where the intervention in the plan of care was not in place.

In an interview with the DOC, they confirmed that the intervention should be in place as specified in the care plan.

Sources: Resident's clinical records; interviews with staff; observations.
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