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

Original Public Report

Report Issue Date: August 21, 2024

Inspection Number: 2024-1181-0003

Inspection Type:
Critical Incident
Follow up

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Brierwood Gardens, Brantford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6, 7, 8, 9, 12, 13, and 14, 2024

The following intake(s) were inspected:

- Intake: #00117649 - Follow-up - CO #001, FLTCA, 2021 - s. 6 (7), Plan of care.
- Intake: #00117650 - Follow-up - CO #002, FLTCA, 2021 - s. 184 (3) Directives by Minister related to IPAC.
- Intake: #00117651 - Follow-up - CO #004, O. Reg. 246/22 - s. 102 (9) (b), IPAC.
- Intake: #00117652 - Follow-up - CO #003, O. Reg. 246/22 - s. 102 (2) (b), IPAC.
- Intake: #00117653 - Follow-up - CO #005, O. Reg. 246/22 - s. 102 (11) (b), IPAC.
- Intake: #00119234 - CI-2678-000023-24 - Alleged neglect of resident.
- Intake: #00120061 - CI-2678-000025-24 - ARI outbreak.

- Intake: #00120651 - CI-2678-000027-24 - Alleged staff to resident abuse resulting in injury.
- Intake: #00123117 - CI-2678-000031-24 - ARI - Parainfluenza virus Outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1181-0002 related to FLTCA, 2021, s. 6 (7)
Order #002 from Inspection #2024-1181-0002 related to FLTCA, 2021, s. 184 (3)
Order #003 from Inspection #2024-1181-0002 related to O. Reg. 246/22, s. 102 (2) (b)
Order #004 from Inspection #2024-1181-0002 related to O. Reg. 246/22, s. 102 (9) (b)
Order #005 from Inspection #2024-1181-0002 related to O. Reg. 246/22, s. 102 (11) (b)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that residents were not neglected by the licensee or staff.

Rationale and Summary
According to O Reg 246/22 s. 7, for the purposes of the Act and this regulation "Neglect" — means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident (CI) was submitted by the home related to alleged 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 resident had a Cognitive Performance Scale (CPS) score that was high, with a history of responsive behaviours. The resident required extensive assistance with all activities of daily living and was unable to direct their own care.

A staff member did not provide the required care for the resident and as a result, the resident's health and well being were jeopardized as documented in the clinical record.

As a result of the failure to provide the resident with the care required this led to an alteration in the resident's health and well-being.

Sources: Record review of clinical records, Critical Incident (CI), home's investigation notes; observations of the resident and interviews with staff and management.

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) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure that the resident received an appropriate assessment by an authorized person upon return from hospital.

Rationale and Summary
The resident was noted to have a change in status and therefore required medical intervention.

In a review of the resident's clinical record, no appropriate assessment or documentation was noted at the appropriate time.

The Director of Care confirmed that the resident should have had a specific assessment and they did not.

There was risk to the resident for altered health and well being due to lack of appropriate assessments at the appropriate intervals.

Sources: Record review of clinical records, Critical Incident(CI), home's investigation notes and Procedure CARE12-O10.01, Effective date: August 31, 2016, Reviewed date: March 31, 2024; observations of the resident and interviews with staff and management.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that the resident, who exhibiting altered health status, received a proper assessment by an authorized person, using a clinically appropriate assessment instrument.

Rationale and Summary
The resident was noted to have a change in status and therefore required medical intervention.

In a review of the resident's clinical record, no appropriate assessment or documentation was noted at the appropriate time.

The Director of Care confirmed that the resident should have had a the appropriate assessment and they did not.

There was risk to the resident for further decline in altered health and well being due to lack of appropriate assessments at the appropriate time.

Sources: Record review of clinical records, Critical Incident(CI), Home's investigation notes and Procedure CARE12-O10.01, Effective date: August 31, 2016, Reviewed date: March 31, 2024; observations of the resident and interviews with staff and management.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that, for the resident, who had specific needs, that strategies were developed and implemented to respond to those needs.

Rationale and Summary
A critical incident (CI) was submitted related to alleged abuse of the resident by staff

that resulted in harm to the resident.

During care, the resident sustained an injury which required medical intervention.

Staff confirmed the resident had specific needs to be managed with interventions and strategies identified to be used curing care and that these needs of the resident were not new.

The resident's plan of care did not include a focus related to those specific needs or interventions to be used to manage those needs.

A staff member confirmed that the specific interventions needed to manage the resident's needs were not in the plan of care and should have been.

The lack of strategies and interventions in place in the resident's plan of care put the resident at an increased risk.

Sources: Record review of clinical records, CI, and the home's investigation notes; observations of the resident and interview with staff and management.

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