Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 13, 2014	2014_189120_0007	H-000033/34/35-14	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 29 & 30, 2014

Non-compliance was previously identified during an inspection conducted on November 14, 2013 related to infection prevention and control, maintenance and housekeeping services. Three Orders were issued on Dec. 2, 2013 on inspection report #2013-189120-0084. Two out of the three Orders met the conditions required and one remains outstanding and non-compliant regarding furnishings and equipment. See below for details.

During the course of the inspection, the inspector(s) spoke with the administrator, environmental services supervisor and non-registered staff.

During the course of the inspection, the inspector(s) toured the building, observed the condition of both soiled utility rooms, resident's night tables, beds and personal care articles (bed pans, basins) and specific resident washroom floors. Reviewed infection control policies and procedures and a resident bed rail needs assessment audit.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home was kept clean and sanitary.

The flooring material located in four identified resident bedrooms were observed to be very dirty in appearance. Particles were stuck to the floor and foot traffic patterns were quite visible (black areas). According to housekeepers, the floors are mopped daily, but their equipment and actions are not able to adequately remove the stuck on particles and built up soil. The flooring in the identified rooms are one piece sheet vinyl that offers an anti slip surface and therefore may require specialized equipment to remove built-up residues. [s. 15(2)(a)]

2. The licensee has not ensured that furnishings and equipment were maintained in a safe condition and in a good state of repair.

1. Resident beds located in approximately six bedrooms were identified to have loose to very loose bed rails. The rails were unsteady and moved substantially toward and away from the mattress, creating a large gap and a potential entrapment zone. The bed models in these rooms were labeled as "Carroll" beds and are over 10 years of age. The rails worked by pulling on a knob which released the rail so that it could be rotated up or down. The management of the home were not able to repair the loose rails and instead implemented a system whereby cable ties were used to tie down the rail to the bed frame or certain rails were removed to prevent staff or residents from using them. However, the rails that were required to be tied down were identified to be fully available for use during the inspection. The non-compliance was identified to management on January 29, 2014. On January 30, 2014, maintenance staff were observed removing the loose rails from some of the identified beds. According to the Associate Director of Care, the residents were assessed to ensure that they did not require bed rails for any assessed need.

2. Approximately thirty beds did not have all four mattress keepers applied to the bed frames and the mattresses were able to slide from side to side, especially when rails were removed or in the down position. According the the administrator, mattress keepers had been ordered but no documentation could be provided to substantiate the order. The documentation request was made again on February 5, 2014 from the maintenance manager and on February 13, 2014 from the administrator.

3. Fourteen night tables in resident rooms were replaced on January 29, 2014, however approximately twenty additional night tables which were identified to be in poor condition (exposed particle board tops) during the inspection were on back order. According to the administrator, forty night tables were ordered in December 2013, but

she was not able to produce any documentation from the manufacturer that they had been ordered and remained on back order. The documentation request was made again on February 5, 2014 from the maintenance manager and on February 13, 2014 from the administrator.

Previously issued on December 2, 2013 as Order #001 on inspection report #2013-189120-0082. The home did not meet all of the requirements of the previously issued Order related to mattress keepers, bed rails and night tables. [s. 15(2)(c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Specifically failed to comply with the following:

s. 305. (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home. O. Reg. 79/10, s. 305 (3).
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents. O. Reg. 79/10, s. 305 (3).

Findings/Faits saillants :

1. The licensee commenced work to convert resident lounge space to office space for staff without first receiving the approval of the Director.

When the home was built and licensed, it was required to provide lounge space for their residents as part of their license agreement. One lounge room was approved to be located in each of the two main corridors, located in what is known as the 300 and 400 wings. During the inspection, the lounge space in the 300 corridor had several desks and book cases in it and staff working in the room. Several managers expressed that residents were not using the lounge space and they felt that due to a shortage of office space for staff, that it could be converted to office space. The management of the home did not make their intentions to convert the space known to inspectors or to the Health Capital Investment Branch of the Ministry of Health and Long Term Care and therefore no approval was granted. [s. 305(3)1]

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 licensee does not commence any alterations to the home without first receiving approval from the Director., to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

Ontario

Ministry of Health and Long-Term Care

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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 86. (2)	CO #003	2013_208141_0016	120
LTCHA, 2007 S.O. 2007, c.8 s. 86. (2)	CO #003	2013_189120_0082	120
O.Reg 79/10 s. 87. (2)	CO #002	2013_189120_0082	120

Issued on this 18th day of February, 2014

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

B. Sosnik

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2014_189120_0007
Log No. / Registre no:	H-000033/34/35-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 13, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BRIERWOOD GARDENS 425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHERINE DONAHUE

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_189120_0082, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall;

1. Install mattress keepers on all four corners of beds where required. If mattress keepers are not able to be installed by February 28, 2014, provide a copy of the invoice from the manufacturer identifying a delivery date and the invoice is to be emailed or faxed to the Inspector by February 28, 2014.
2. Ensure that all bed rails are in good mechanical working order and have been tested to pass all 4 zones of entrapment. Documentation shall be maintained of the bed inspections and entrapment zone audits.
3. Immediate actions shall be taken to mitigate risks to residents who reside in beds and who use bed rails where the rail does not pass all zones of entrapment. Documentation shall be maintained as to the course of action taken for these residents.
4. Provide a copy of an invoice from the furniture (night table) manufacturer indicating the date(s) of delivery. Documentation shall be maintained at the home of all maintenance inspections of the night tables and other resident furnishings.

A copy of the invoice identified under #4 shall be emailed to Bernadette.Susnik@ontario.ca or faxed to the Hamilton Service Area Office 905-546-8268 by February 18, 2014.

Grounds / Motifs :

1. The licensee has not ensured that furnishings and equipment were maintained in a safe condition and in a good state of repair.

1. Resident beds located in six identified bedrooms were identified to have loose to very loose bed rails. The rails were unsteady and moved substantially toward and away from the mattress, creating a large gap and a potential entrapment zone. The bed models in these rooms were labeled as "Carroll" beds and are over 10 years of age. The rails worked by pulling on a knob which released the rail so that it could be rotated up or down. The management of the home were not able to repair the loose rails and instead implemented a system whereby cable ties were used to tie down the rail to the bed frame to prevent staff or residents from using them. However, the rails were identified to be fully available for use during the inspection. The non-compliance was identified to management on January 29, 2014. On January 30, 2014, maintenance staff were observed removing the loose rails from some of the identified beds. According to the Associate Director of Care, the residents were assessed to ensure that they did not require bed rails for any assessed need.

2. Approximately thirty beds did not have all four mattress keepers applied to the bed frames and the mattresses were able to slide from side to side, especially when rails were removed or in the down position. According the the administrator, mattress keepers had been ordered but no documentation could be provided to substantiate the order. The documentation request was made again on February 5, 2014 from the maintenance manager and on February 13, 2014 from the administrator.

3. Fourteen night tables in resident rooms were replaced on the first date of inspection, however approximately twenty additional night tables which were identified to be in poor condition (exposed particle board tops) during the inspection were on back order. According to the administrator, forty night tables were ordered in December 2013, but she was not able to produce any documentation from the manufacturer that they had been ordered and remained on back order. The documentation request was made again on February 5, 2014 from the maintenance manager and on February 13, 2014 from the administrator.

Previously issued on December 2, 2013 as Order #001 on inspection report

#2013-189120-0082. The home did not meet all of the requirements of the previously issued Order related to mattress keepers, bed rails and night tables. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13th day of February, 2014

Signature of Inspector / Signature de l'inspecteur : B. Susnik

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

Service Area Office / Bureau régional de services : Hamilton Service Area Office