MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 1102736

PREPARED FOR: Honorable Adrian Dix, Minister **- FOR INFORMATION**

TITLE: Overdose Death at Assisted Living Residence.

PURPOSE: To provide background information about the overdose death s.22
s.22

BACKGROUND:

s.22 the Assisted Living Registry (Registry) received a serious incident report of an unexpected death
s.22
It was reported that 911 was called, with paramedics and RCMP responding.

A Registry investigator reviewed the serious incident report, and noted that s.22 staff contacted the manager of the residence prior to calling 911. The investigator followed up with s.22 to inquire about this, and provided information to the manager about the necessity of calling 911 immediately. The manager agreed to ensure that all house staff would be trained to call 911 prior to contacting the manager. The investigator's review of the serious incident did not identify any other health and safety issues that warranted further investigation at that time.

the Assisted Living Registry received a telephone complaint from s.15,s.22 , and alleged that proper intake policies were not in place

s.15,s.22

DISCUSSION:

An investigation was initiated by the Assisted Living Registry in response to s.15,s.22 complaint and concerns. After reviewing documents and conducting interviews, it was determined, based on a balance of probabilities (which is the standard of proof used by the Registry) that there were a number of areas were in non-compliance with the Community Care and Assisted Living Act and the Assisted Living Registrar's Health and Safety Standards. The areas of non-compliance were as follows:

- Health and Safety Standard #4 - Staff have the right skills and competencies to do their job.

- Health and Safety Standard #5 - Potential residents are screened before entering the residence, and residents participate in exit planning to support any transitions out of the residence.

Although it was determined that there were areas of non-compliance with the health and safety standards, there was no evidence found during the investigation that indicated that either the actions or inactions of staff s.22 contributed to s.22 death.

ADVICE:

The residence has since addressed all identified areas of non-compliance, and the investigation is now concluded. Once s.22 has been notified of the findings, the Assisted Living Registry will post the standards that were found to be in non-compliance on the Assisted Living Registry website for a period of two years. It will also be noted on the posting that the registrant is now in compliance.

Program ADM/Division: Ted Patterson, Primary & Community Care Policy Division, Seniors Services, Assisted Living Registry
Date: February 23, 2017