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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 5, 2015	2014_323130_0025	H-001678-14	Resident Quality Inspection

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

THE BRANT CENTRE
1182 NORTHSHORE BLVD. EAST BURLINGTON ON L7S 1C5

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

GILLIAN TRACEY (130), CATHY FEDIASH (214), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 9, 10, 11, 12, 15 and 16, 2014

Please Note: The following Critical Incident Inspection was conducted concurrently with this RQI: H-000546-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Nurse Manager, Resident Assessment Instrument (RAI) Coordinator, Infection Control/Quality Manager, Registered staff, personal care providers (PCP's), President Residents' Council, President Family Council, dietary staff, recreation staff, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out, (a) the planned care for the resident.

A) An interview with resident #100 and a review of the clinical record confirmed that the resident had a specific medical intervention in place during an identified period of time in 2015. During this time period, the written plan of care did not identify the medical intervention, care of the area it pertained to, nor interventions to manage any risks associated with this medical intervention. This information was confirmed by the Registered staff. (Inspector #130)

B) A review of resident #109's written plan of care dated 2014, indicated that the resident required extensive assistance with two staff to transfer on and off the toilet. A review of the Point of Care (POC) documentation during the same time period, indicated that on the night shift, the resident was toileted with one person physical assistance. During an interview, the DOC indicated that during the night shift the resident was not physically toileted but had their continence care needs addressed with one staff providing care

while the resident was in bed. The DOC confirmed that the written plan of care had not identified the planned care for the resident. (Inspector #214) [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

A) A review of resident #103's plan of care that was located electronically in the Point Click Care (POC) documentation system indicated on a specified date in 2014, that a physical restraint was implemented. The printed copy of the plan of care, located in the care plan binder and that plan accessed by front line staff, had the same print date as the PCC plan and had not included the use of the physical restraint. A review of the resident's kardex located in POC, which staff use for direction, also had not identified the use of the physical restraint. An interview with Registered staff confirmed that changes to the resident's plan of care were to be handwritten on the paper copy and had not been. As a result, direct care staff were not kept aware of the contents of the resident's plan of care and did not have convenient and immediate access to it. (Inspector #214)

B) On three observed dates in 2014, resident #101 was observed with a physical restraint applied. The resident's clinical records indicated they had a change in their plan of care on a specified date in 2014, to include the physical restraint. The home's electronic plan of care accessible only to Registered staff included the change; however the printed plan of care and the electronic kardex used by PCP's to provide direction for the resident's care needs did not contain information about the physical restraint and directions for its use. This was confirmed by the Assistant Director of Care (ADOC). (Inspector #585) [s. 6. (8)]

3. The licensee failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or when a goal was met.

A) The written plan of care for resident #100 indicated the resident had a specific medical intervention in place; however, the resident, who was competent, confirmed the medical intervention changed on a specified date in 2014, to a different medical intervention. The new medical intervention remained in place for a specified period of time in 2014. This information was confirmed in the clinical record. Registered staff confirmed the written plan was not updated when the resident's care needs changed. (Inspector #130)

B) The Quarterly Minimum Data Set (MDS) Assessment completed on a specified date in 2014, for resident #100 indicated the resident had three alterations to their skin. The Head to Toe Skin Assessment completed around the same time period, indicated the skin was intact. The written plan of care reviewed and revised sometime later in 2014, indicated the resident still had alterations to their skin. Registered staff confirmed the written plan of care was not updated when the alterations in skin had healed and the planned goal was met. (Inspector #130) [s. 6. (10) (b)]

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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident, to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, a goal in the plan is met, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable

requirements under the Act.

A) A review of the home's policy, "Resident Falls, LTC-CA-WQ-200-07-08" last revised November 2014, stated that "a Post Fall Analysis will be completed by the interdisciplinary team where indicated by the decision tree in Appendix A", as follows: For residents identified at high risk for falls, the decision tree directed staff to complete a Post Fall Analysis when it was the resident's first fall in the quarter, and that a Post Fall Analysis was not required to be completed if the resident experienced subsequent falls in the same quarter. For residents identified at medium risk for falls, the decision tree directed staff to complete a Post Fall Analysis when it was the resident's first fall in the month, and that a Post Fall Analysis was not required to be completed if the resident experienced subsequent falls in the same month.

The home's decision tree instructed Registered staff to also complete a Risk Management note with any fall occurrence; however the Risk Management document stated it was "Privileged and Confidential - not part of the Medical Record – Do not Copy". This was confirmed by the DOC. Ontario Regulation 79/10, r. 49 (2) indicates that "when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls." The home's policy did not direct staff to assess residents using a clinically appropriate assessment instrument specifically designed for falls when a resident has fallen where the condition or circumstances of the resident require a post fall assessment. (Inspector #585) [s. 8. (1) (a)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system implemented was complied with.

A) The home's policy, "Resident Falls, LTC-CA-WQ-200-07-08" last revised November 2014, stated that a Post Fall Analysis was to be completed for residents identified at high risk for falls in circumstances where they experienced their first fall in the quarter.

Resident #101 was identified as being at risk for falls in 2014. On an identified date in 2014, the resident reported they fell. A review of the resident's clinical record indicated the resident fell; however a Post Fall Analysis was not completed. Registered staff present at the time of the fall confirmed that a Post Fall Analysis was not completed. (Inspector #585)

B) During the RQI, residents and staff reported that ceiling lifts did not always work effectively because the lift batteries had insufficient charge. A PCP reported the home had a procedure, "Daily Cart Ceiling Lift Inspection Checklist" which PCPs and/or health care aides were required to complete every shift to indicate that the lift was visually inspected prior to each use. Part of the inspection included checking to see if the lift battery was fully charged. The Daily Fixed Ceiling Lift Inspection checklist in the Hidden Valley home area was reviewed from December 1 to 15, 2014, and revealed that documentation on the checklist was incomplete 30 out of 45 shifts. The ADOC confirmed the checklist was to be complete each shift, and the home did not comply with the policy for inspecting lifts.(Inspector #585) [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act and complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's skin condition, altered skin integrity and foot conditions.

A) The written plan of care for resident #104 indicated the resident had an alteration in skin to three specified areas. The MDS Quarterly Review assessment completed on a specified date in 2014, indicated the resident had three alterations in skin to different specified areas. Registered staff confirmed the resident had alterations in skin, which were consistent with the MDS assessment. Staff confirmed the written plan of care was not based on the assessment of the resident's altered skin integrity and foot conditions. (Inspector #130) [s. 26. (3) 15.]

2. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

A) Resident #101 reported they had a preference to wake up at a specific time in the morning and they would use their bed call-response system to inform staff when they required assistance to get up. One PCP stated the resident usually requested staff to assist them to wake up by activating their call-response system at a specific time. A second PCP stated the resident usually requested staff to assist them to wake up by activating their call-response system at a different time. The resident's plan of care was reviewed and did not indicate their preference and pattern to wake at their preferred time. This was confirmed by Registered staff. The ADOC stated that a form titled "A Snapshot of my Life" was used as part of an assessment upon admission to collect information on sleep patterns. The resident's clinical record was reviewed and did not include this form, which was confirmed by Registered staff. (Inspector #585) [s. 26. (3) 21.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

A) On an identified date in 2014, resident #100 reported to the Administrator that an agency nurse attempted to provide improper care with respect to a medical intervention that was in place. The Administrator logged the incident in the home's complaint log and investigated the incident. The Administrator confirmed the identified staff was a member of their regular part time complement. The Registered staff provided a written statement indicating they had noted abnormal signs and symptoms with respect to the medical intervention in place and were attempting to address them. The Administrator confirmed that none of the above information was documented in the resident's clinical record. (Inspector #130) [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to minimize restraining dealt with, alternatives to the use of physical devices, including how these alternatives were planned, developed and implemented, using an interdisciplinary approach.

A) A review of the home's policies in relation to minimizing of restraining was completed which included a review of the following policies: Monthly Restraint Evaluation (LTC-CA-ON-200-07-18 with a revision date of July 2014); Physical Restraint (LTC-CA-WQ-200-07-20 with a revision date of November 2014) and Restraint Monitoring Record (LTC-CA-ON-200-07-21 with a revision date of November 2014). A review of the above policies indicated the following in policy Physical Restraint (LTC-CA-WQ-200-07-20):

i)9. As an alternative to restraints, and for the safety of affected residents, residents at risk of falls would have their bed in the lowest possible position when they were in bed.

An interview with the DOC confirmed that the home used several alternatives to restraints, over and above ensuring that residents beds were in the lowest possible position and that those other alternatives were not included in the home's policy to minimize restraining, nor did the policy include how those alternatives were planned, developed and implemented, using an interdisciplinary approach. (Inspector #214) [s. 109. (f)]

Issued on this 12th day of January, 2015

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

Original report signed by the inspector.