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
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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 22, 2016	2015_342611_0014	031631-15	Resident Quality Inspection

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
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

KELLY CHUCKRY (611), IRENE SCHMIDT (510a), ROBIN MACKIE (511)

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): November 19, 20, 23, 24, 25, 26, 27, and 30, 2015

During the course of the inspection, the inspector(s) toured the home, observed the provision of resident care and services, reviewed relevant resident clinical documents, home policies/procedures/practises and meeting minutes.

In addition, seven (7) Critical Incident notification inspections were conducted concurrently with this RQI and included:006872-14, 009064-14, 000367-15, 016259-15, 020112-15, 021003-15, and 027017-15.

One (1) complaint inspection was also conducted concurrently with this RQI and is 001334-14. This complaint inspection has been severed from this RQI report and a separate report will be completed

During the course of the inspection, the inspector(s) spoke with residents, family members of residents, Resident Council Representative, Family Council Representative, the Administrator, Director of Care (DOC), Environmental Supervisor, Programs Manager, Infection Control/Quality Manager, Clinical Nurse Manager, Resident Assessment Instrument (RAI) Coordinator, registered staff, Personal Support Workers (PSW's), dietary aides, and housekeeping aides

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
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. (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. 2007, c. 8, s. 6 (7).

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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The bed rail assessment completed for resident #202 on an identified date, directed the use of one half rail. The care plan completed on an identified date, directed the use of one rail as a personal assistance services device, to promote bed mobility. The Kardex reflected this direction as well. Documentation in the progress notes on two identified dates reported that staff raised two bed rails.

The above was confirmed by the DOC and the Clinical Nurse Manager. Care set out in the plan of care was not provided as specified in the plan. [s. 6. (7)]

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

Resident #031 experienced a significant change in status, and as such, a Minimum Data Set (MDS) 2.0 assessment was completed on an identified date. This assessment indicated that resident #031 was bedfast all or most of the time. A physicians order was obtained on an identified date, indicating that this resident was to be kept in bed and to be non-weight bearing. The order also indicated that the resident may use Broda chair as tolerated. Upon review of the care plan that was reviewed on an identified date, it indicated under sleep and rest needs that resident #031 prefers to go to bed between 2030h and 2100h. It does not indicate that resident is bedfast and therefore the plan of care was not revised when resident #031 care needs changed. This was confirmed by staff #105. [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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date, a quarterly assessment was completed for resident #400. The Resident Assessment Protocol under ADL function/Rehab potential indicated that this resident continued to require extensive assistance by two (2) staff for transferring and toileting needs. The care plan for resident #400 completed on an identified date also indicated that this resident required extensive assistance by two (2) staff for transferring and toileting needs.

On an identified date, resident #400 was transferred from the toilet to a wheelchair with the assistance of one staff member. During this transfer the resident became weak and fell to the floor and sustained an injury as a result.

The staff member did not follow safe transferring techniques when assisting resident #400 with personal care needs. An interview with the Administrator confirmed that an internal investigation was conducted and the staff member was disciplined for conducting this improper/unsafe transfer. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, 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:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's communication abilities, including hearing and language.

The plan of care for resident #034 included specific direction on the care needs regarding speech. MDS completed on an identified date, for resident #034 also included specific direction on the care needs for this resident regaring speech. MDS also reported the resident did not have speech language pathology or occupational therapy (OT) to enhance communication strategies. Review of the clinical record revealed an OT assessment for mobility but not for communication. There was no evidence of an assessment by speech and language pathology related to communication. Resident #034 reported they felt their needs were sometimes not met because staff did not understand what they were saying.

Staff #105, #106 and #107 confirmed that the plan of care for resident #034 was not based on an interdisciplinary assessment of the resident’s communication abilities. [s. 26. (3) 3.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that was conducted using a clinically appropriate assessment instrument specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

At the time of admission, resident #025 had a cognitive performance score (CPS) of two (2). The admission minimum data set (MDS) assessment reported the resident was occasionally incontinent. Review of the clinical record revealed the absence of a continence assessment using a clinically appropriate assessment instrument. This was confirmed by registered staff and the Clinical Nurse Manager. [s. 51. (2) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee of the long-term care home failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

A review of a specific Critical Incident System (CIS) report revealed that the home became aware of an enteric outbreak on an identified date on a specific resident care area. This outbreak was declared over by Public Health on an identified date The CIS indicated the report to the Director was submitted on an identified date, six (6) days after the home had knowledge of the Outbreak and after the Outbreak was declared over by Public Health.

Interview with the Administrator confirmed the home did not ensure the Director was immediately informed of the outbreak of a reportable disease as defined in the Health Protection and Promotion Act. [s. 107. (1) 5.]

Issued on this 25th day of January, 2016

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

Original report signed by the inspector.