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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
Dec 5, 2016	2016_247508_0016	031152-16	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

Chartwell Brant Centre Long Term Care Residence
1182 NORTHSHORE BLVD. EAST BURLINGTON ON L7S 1C5

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

ROSEANNE WESTERN (508), KELLY HAYES (583)

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): October 27, 28, 31, November 1, 2, 3, 4 and 8, 2016.

During this inspection the following complaint and Critical Incident (CI) inspections were conducted during this Resident Quality Inspection (RQI): CI inspection, log #035410-15 related to responsive behaviours, complaint inspection, log #014690-16, related to resident care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Infection Control/Quality Assistant Director of Care, the Clinical Assistant Director of Care, the Environmental Services Supervisor, the Director of Social Services, the Resident Care and Nursing Services Consultant, registered staff, Personal Support Workers (PSW), residents and family members.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
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.
7 WN(s)
4 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

On November 4, 2016, it was observed on the fourth floor in the Nurse Educator office that a treatment cart was in the entrance way with the door propped open. The office is located in between two Resident Home Areas (RHA).

The room was unoccupied and the treatment cart contained dressing supplies including, scissors, a bottle of rubbing alcohol and hydrogen peroxide which were sitting on the top of the cart, accessible to residents.

The Inspector informed the Clinical Assistant Director of Care who confirmed that the treatment cart should have been in a secured room. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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 the plan of care was revised at any time when the residents care needs change or care set out in the plan had not been effective.

A review of resident #008's Risk Management fall incident summary provided by the Infection Control/Quality Assistant Director of Care on November 2, 2016, identified the resident had five falls on identified dates in 2016. A review of the progress notes identified the falls occurred when the resident was wandering in the corridor or in other residents' rooms.

A review of the current falls care plan identified that resident #008 had two falls from bed to floor. Revisions made to the falls care plan from July to August, 2016, did not include information about the resident wandering. In an interview with the Clinical Assistant Director of Care on November 8, 2016, it was confirmed the falls care plan did not identify the resident was at risk of falls related to wandering. It was confirmed the care plan was not revised when interventions set out in the plan had not been effective. [s. 6. (10) (b)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer effective.

Resident #004 was a high risk for falls and had falls prevention interventions identified in their current plan of care. The resident's plan of care directed staff to use a specific intervention when the resident was up in the wheelchair or when the resident was in a chair at all times.

Interviews with staff #100 and staff #101 indicated that the resident is only up in the wheelchair at certain times and is then put back to bed. The resident is no longer transferred to a chair other then a wheelchair. Observation of the resident's room revealed that the resident no longer had the chair in their room. This was also confirmed by staff #100.

Staff #100 and staff #101 confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. [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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to minimize the restraining of residents was complied with.

Resident #008 was a high risk for falls and had an order for a restraining device to be applied as needed (PRN) when the resident was in a wheelchair for safety.

It was observed on several identified dates during this inspection that resident #008 was in the wheelchair with the restraining device on.

A review of the home's policy titled "Restraint Monitoring Record" with a revision date of July 2015, directed registered staff to review the Restraint Monitoring Record at the end of their shift and initial in the appropriate space. In homes with the Point of Care (POC) technology, registered staff will initial the ongoing need for the restraint application in the Electronic Medication Administration Record (eMAR) system.

During an interview with registered staff #103 on November 9, 2016, it was revealed that registered staff were only signing for the application of the restraint and the effectiveness in eMAR. The ongoing need for the restraint application to be assessed and initialed by registered staff at the end of each shift was not being done. This was confirmed during a review of the eMAR documentation for October and November, 2016.

It was confirmed by staff #103 and by documentation that the written policy to minimize the restraining of residents was complied with. [s. 29. (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 there is a written policy to minimize the restraining of residents and to ensure that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (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 a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Resident #005 had an alteration in their skin integrity which included wounds on several areas of their body. A review of the resident's clinical record indicated that the resident had been hospitalized on an identified date in 2016 due to a change in condition.

The resident was readmitted back to the home with these wounds still present. A review of the resident's clinical record indicated that the resident did not receive a skin assessment until six days after the resident was re-admitted back to the home from hospital.

This information was confirmed through documentation and during an interview with the Quality Assistant Director of Care on November 1, 2016. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

Resident #001 had a wound on their extremity which required dressing changes three times per week and when necessary (PRN). Weekly skin assessments were scheduled for a specific day of the week.

A review of the resident's clinical record indicated that on three identified dates in September and October 2016, the resident's weekly skin assessment had not been completed by registered staff. Registered staff indicated in their documentation on these identified dates that they had not completed these assessments as this was done by the wound care nurse.

During an interview with the home's Wound Care Lead, it was revealed that weekly skin assessments are to be conducted by the registered staff assigned to the resident care areas.

It was confirmed during interviews with the Assistant Director of Care (ADOC) and the Wound Care Lead that resident #001 had not been reassessed at least weekly by a member of the registered nursing staff when clinically indicated. [s. 50. (2) (b) (iv)]

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 residents exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff upon return from hospital and at least weekly, to be implemented voluntarily.

WN #5: 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. Where the Act or this Regulation required the licensee to have, institute or otherwise put in place any policy the licensee failed to ensure that the policy was in compliance with and was implemented in accordance with applicable requirements under the Act.

A review of resident #008's Risk Management fall incident summary identified that the resident had five falls on identified dates in 2016. In an interview with the Infection Control/Quality Assistant Director of Care on November 2, 2016, it was confirmed that a post fall assessment using a clinically appropriate assessment instrument specifically designed for falls was not completed for four of the five falls per the home's policy.

A review of the home's policy, "Resident Falls, LTC-CA-WQ-200-07-08" last revised May 2016, stated that "a Post Fall Analysis will be completed by the interdisciplinary team where indicated by the decision tree in Appendix A". 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 on the documentation on resident #008's Risk Management fall incident summary. 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.

In an interview with the Resident Care and Services (RCS) Consultant on November 3, 2016, it was confirmed that this area of non-compliance was issued in the Resident Quality Inspection report dated January 5, 2015. The RCS Consultant confirmed the "Resident Falls, LTC-CA-WQ-200-07-08" last revised May 2016, had not content had not been revised to meet the legislative requirements pertaining to O.Reg. 79/10, s. 49(2). [s. 8. (1) (a),s. 8. (1) (b)]

2. Where the Act or this Regulation required the licensee to have, institute or otherwise put in place any policy the licensee failed to ensure that the policy was complied with.

During a review of resident #400's progress notes it was documented on an identified date in 2015, that a care conference was held stating, "Family had several concerns that had been addressed by staff." A review of the home's policy titled, "Care Conferences" LTC-CA-WQ-100-02-12, revised May 2016, directed staff under the procedures section to document the conference on the Care Conference form. The Care Conference form completed for section "K –Resident/Family a. Expectations/Concerns" did not contain documentation. In an interview with the Director of Social Services on November 3, 2016 , it was confirmed that the family concerns that were brought forward and discussed with the interdisciplinary team were not documented in section K of the Care Conference form.

PLEASE NOTE: This area of non-compliance was identified during a Compliant Inspection, log # 014690-16, conducted concurrently during this Resident Quality Inspection. [s. 8. (1) (b)]

3. A review of the home's policy titled, "Care Conferences" LTC-CA-WQ-100-02-12, revised May 2016, directed staff under the procedures section to document the conference on the Care Conference form.

A review of the clinical record for resident #008 indicated that the resident's post-admission care conference was held on an identified date in 2016. The Care Conference form was reviewed and it was identified that this form was incomplete. The form did not contain the information discussed at the resident's care conference. The documentation required in section "D" - Nursing Summary, section "H - Pharmacy Summary", section "J - Physician Summary"and section "K - Resident/Family a. Expectations/Concerns" was blank.

Further review of the resident's clinical record revealed that in the progress notes a summary of discussions held with the resident's POA had occurred during the care conference; however, staff did not comply with the home's policy.

In an interview with the Director of Social Services on November 3, 2016, it was confirmed that these sections of the form had not been completed. It was also confirmed that the Care Conference policy had not been complied with. [s. 8. (1) (b)]

WN #6: 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 interventions were documented.

A review of resident #003's plan of care identified they used tilt function for their wheel chair which was assessed as a personal assistance services device (PASD) used for comfort and positioning. The care plan directed staff to monitor the resident every hour when tilted and to reposition the resident every two hours for comfort, safety and offload. A review of the Point of Care (POC) tasks identified there were no tasks created for monitoring the resident when in tilt or for repositioning every two hours when in the resident was in their chair.

In an interview with the Administrator it was confirmed that there was no documentation of these interventions for resident #003. In an interview with the Resident Care and Services (RCS) Consultant on November 3, 2016, it was confirmed that it was the home's expectation that these actions did not require documentation. [s. 30. (2)]

2. 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.

Resident #008 had a restraining device on their wheelchair that was to be applied only as needed for safety. The registered staff applying the restraint were to document the application of this restraint in the Electronic Medication Administration Record (e-MAR) by signing their initials.

During this inspection the resident was observed by the Inspectors in a wheelchair with a restraining device applied. A review of the documentation in the e-MAR on November 8, 2016, identified that the registered staff had not documented the application of the restraint when the resident was observed in a wheelchair with the restraining device applied.

An interview with the Clinical ADOC and the documentation reviewed on November 8, 2016, confirmed that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were not documented. [s. 30. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or in a medication cart that was secured and locked.

On November 8, 2016, at approximately 1330 hours, a medication cart was observed by Inspector #583 and Inspector #508 in the hallway on the second floor across from the nursing station.

The medication cart was observed to be unattended and when checked it was confirmed that it was unlocked. The registered staff working on this unit who was observed across the hallway in the dining room came over to the cart and secured it.

It was confirmed through observation and by the RPN that drugs were not stored in a medication cart that was secured and locked. [s. 129. (1) (a) (ii)]

Issued on this 13th day of December, 2016

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

Original report signed by the inspector.