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 prévue 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 soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 24, 2019	2018_587129_0012	000832-18, 018747-18, 020321-18, 025583-18	Complaint

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 11, 12, 14, 18, 19, 20, 21, 2018, January 9, 10, 11, 2019.

The following complaint inspections were completed:
018747-18 related to care supplies, laundry services, staffing, abuse and falls
000832-18, 025583-18, 020321-18 related to Registered Nurse staffing

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPN), Registered Nurses (RN), Wound Care/Clinical Quality Coordinator, PSW Coordinator, Nursing Unit Clerk, the Director of Care (DOC) and the Administrator.

During the course of this inspection the Inspector observed resident care, reviewed clinical documentation, reviewed care records maintained by the home, reviewed staffing schedules for Registered Nurses and Personal Support Workers, reviewed availability of care supplies, reviewed practices related to missing personal items and laundry as well as reviewed licensee's policies (Staffing Standards, Falls Prevention, Abuse, Bathing and Complaints).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 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	Légende 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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Resident bathing records were reviewed and indicated:

1. Resident #002's clinical record indicated staff had documented that the resident refused their scheduled baths on identified dates in November 2018, which indicated the resident was not provided with two baths a week for the the identified dates in November 2018. A review of the clinical record confirmed there was no documentation related to the refusal of the above noted scheduled baths or any indication in records that a bath had been offered on an alternate date or at an alternate time. Resident #002's written plan of care indicated a care focus related to refusal of care, not specifically bathing, and directed staff that if the resident refused care staff were to re-approach the resident in order to ensure that the care was provided.

2. Resident #008's clinical record indicated staff had documented that the resident had been assisted to bathe on an identified date in November 2018, and the next bath was documented the following week, which indicated that for the identified dates in November 2018 resident #008 had not been provided with two bath. Resident #008's written plan of care specified the resident was to have two baths a week.

3. Resident #009's clinical record indicated staff had documented that the resident was assisted to bathe on an identified date in November 2018 and the next bath was documented the following week, which indicated that for the identified dates in November 2018 resident #009 had not been provided with two baths. Resident #009's written plan of care specified the resident was to have two baths a week.

During an interview with the Director of Care (DOC), they reviewed the clinical notes and records related to bathing for resident #002, resident #008 and resident #009. At this time the DOC confirmed that the above noted residents had not been provided with assistance to bath two times a week. The DOC indicated that based on the fact that there was no documentation related to an alternative to the scheduled baths, that it was their conclusion that the identified residents had not been provided with a minimum of two baths/showers during the above noted periods. [s. 33. (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 and ensuring that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure 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. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

a) Resident #001 and resident #002 were not assessed related to a potential head injury.

i) On an identified date and time, a clinical note documented by Registered Nurse (RN) #109 indicated that resident #001 had experienced a fall and was found to be lying on the floor. The documentation indicated that; upon examination the resident exhibited identified physical signs of injury.

Staff did not to assess resident #001's condition related to a potential head injury. At the time of the above noted fall, RN #109 who attended the resident, observed evidence that resident #001 had sustained an injury when they documented specific observations

made at the time.

Registered Practical Nurse (RPN) #106 confirmed that they are to complete a head injury assessment following all unwitnessed falls.

It was verified by the DOC on an identified date, RPN #106 and clinical documentation that the resident had not been assessed related to a potential head injury at the time of the fall or subsequently, at any time when the resident returned from hospital.

ii) On an identified date and time, a clinical note documented by RN #109 indicated that resident #002 experienced a fall and that they had hit their head during the fall. The note indicated RN #109 observed obvious signs of a potential head injury.

Staff did not assess resident #002's condition related to a potential head injury. At the time of the above noted fall, RN #109 who attended the resident, documented observed evidence that resident #002 had sustained an injury to their head.

Following a review of the computerized clinical record and the paper clinical file RPN #110 confirmed there was no documented evidence that the resident was assessed for a potential head injury, either at the time of the incident or at any time following the resident's return from hospital.

The DOC confirmed that in accordance with the licensee's policy "Head Injury Routine", identified as #LTC-CA-WQ-200-07-04 with a revised date of August 2018, staff are expected to follow the directions in the policy that included; "any resident who may have sustained and injury to their head as a result of a fall or other such incident where the resident's head may have come in contact with a hard surface will have a head injury routine initiated".

b) Post fall assessments had not been completed for resident #001 and resident #002 after they experienced falls that resulted in injuries.

i) Staff did not complete a post fall assessment following a fall resident #001 experienced on an identified date. RN #109 documented specific observations they made when they attended the resident.

On an identified date the DOC, RPN #106 and clinical documentation verified that despite the condition of the resident and the circumstances identified at the time of the

fall, a post fall assessment had not been completed in order to determine causative factors that lead to the incident or actions to take to prevent a recurrence.

ii) Staff did not complete a post fall assessment following a fall resident #002 experienced on an identified date. RPN #110 and the computerized clinical record confirmed that a Post Fall Analysis report was initiated on an identified date, when staff selected data point that reflected the observations made at the time of the incident, however there was no documentation to indicate who participated in this process, what the selected data points meant for the future care of the resident, what strategies would be implemented or subsequent evaluation of any interventions implemented as a result of the analysis.

On an identified date the DOC reviewed the Post Fall Analysis form and verified that an analysis of the data points identified had not been completed.

The DOC confirmed that in accordance with the licensee's policy "Resident Falls", identified as #LTC-CA-WQ-200-07-08 with a revised date of December 2017, staff were expected to follow directions that included; "the interdisciplinary team is responsible for meeting and completing the Post Fall Analysis, further they are responsible for implementation and subsequent evaluation of the interventions implemented as a result of the analysis".

The DOC, RPN #106, RPN #110 and clinical documentation confirmed that resident #001 and resident #002 were not assessed for a potential head injury following falls they experienced and did not have a post falls assessment completed as required. [s. 49. (2)]

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 and ensuring that when a resident has fallen, the resident is assessed and 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, expect as provided for in the regulations.

Chartwell Brant Centre is a 175 bed long-term care home.

The following was confirmed by the DOC, staff #102, computerized schedules, daily working schedules and printouts of palm scans:

a) On an identified date, there was not a Registered Nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home between 1900 hours and 0700 hours. The regularly scheduled RN had notified the home they were unavailable to work the scheduled shift and a RN from an employment agency was the only RN in the home for the above noted period of time.
b) On an identified date, there was not a Registered Nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home between 1900 hours and 2300 hours. The regularly scheduled RN had notified the home they were unavailable to work the scheduled and an RN from an employment agency was the only RN in the home for the above noted period of time.

Information provided by the home and verified by the DOC and staff #102 confirmed that the licensee did not ensure that at least one registered nurse who is both an employee of the licensee and a member of the and a member of the regular nursing staff of the home was on duty and present in the home at all times. [s. 8. (3)]

WN #4: 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 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, was complied with.

In accordance with s. 21 of the Long-Term Care Homes Act 2007, "every licensee of a Long-Term Care Home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and how the licensee deals with complaints".

The licensee failed to ensure that the licensee's policy "Complaints", identified as LTC-CA-WQ-100-05-09 with a revised date of June 2017, was complied with. This policy directed that; "an investigation will be initiated immediately into any complaint, written or verbal, that alleges harm or risk of harm to one or more residents".

Registered Nurse (RN) #113 did not immediately initiate an investigation when they received a complaint related to the care of resident #012. Clinical documentation made by RN #113 indicated that on an identified date they received a complaint about the care of the resident.

During an interview, RN #113 confirmed that they did not assess resident #012 following allegations made in the complaint, did not initiate an immediate investigation into the complaint and did not report this complaint to the Director of Care or the Administrator.

RN #113 confirmed they had not complied with the licensees policy when they acknowledged they had not investigated the complaint about inappropriate care provided to resident #012. [s. 8. (1) (b)]

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Issued on this 25th day of January, 2019

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

Original report signed by the inspector.