Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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 4, 2021	2020_788721_0037	007298-20, 015972-20, 017088-20, 020047-20, 022206-20, 023621-20	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

MEAGAN MCGREGOR (721)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 15-18, 21-23, and 29-30, 2020.

The following Critical Incident System (CIS) intakes were inspected during this CIS inspection:
Log #007298-20, CIS #2900-000009-20 related to an unexpected death;
Log #015972-20, CIS #2900-000015-20 related to an injury of unknown cause;
Log #017088-20, CIS #2900-000016-20 related to falls prevention and management;
Log #020047-20, CIS #2900-000017-20 related to falls prevention and management;
Log #022206-20, CIS #2900-000020-20 related to improper care; and
Log #023621-20, CIS #2900-000023-20 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Business Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also observed staff interactions with residents, the care being provided to residents and falls prevention management practices in the home; and reviewed clinical records and plans of care for the identified residents and the home's documentation related to the incidents.

This inspection was conducted concurrently with Complaint Inspection #2020_848748_0007.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was transferred as specified in their plan of care.

The residents plan of care indicated they required a specific type of transferring. A PSW transferred the resident between surfaces by a method of transferring that was different than the method outlined in their plan of care. During the transfer the resident started to fall and the PSW grabbed onto them to prevent them from falling resulting in them sustaining an injury.

A PSW explained that the resident required a specific type of transferring and this was communicated to PSW staff via the transfer logo on the wall behind their bed and in their care plan. They recalled that on this date the PSW who transferred the resident did not review the residents transfer care needs prior to transferring them and did not transfer them as specified in their plan of care.

Sources: the resident's progress notes, care plan and transfer logo; and interviews with a PSW, the ADOC and other staff. [s. 6. (7)]

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.

Issued on this 5th day of January, 2021

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

Original report signed by the inspector.