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 28, 2021	2020_848748_0007	011006-20, 021240-20	Complaint

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

EMMY HARTMANN (748), MEAGAN MCGREGOR (721)

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 15, 16, 17, 18, 23, 29, 30, 31, 2020, January 4, 5, 6, 7, and 8, 2021.

The following intakes were completed during this inspection:

Log #011006-20 was a complaint related to resident care issues including abuse and wound care.
Log #021240-20 was a complaint related to resident care issues including wound care, medication management and documentation.

This inspection was completed concurrently with Critical Incident Inspection (CIS) #2020_788721_0037, in which inspector #721 was present during the inspection.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Assistant Director of Care (DOC), Human Resources (HR) Manager, Skin Care Coordinator, registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 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	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an alleged abuse of a resident, which was reported to the licensee in May 2020, was immediately investigated.

The HR Manager identified that they were involved in investigating an allegation of abuse by a staff member towards a resident. They indicated that the complaint came from a staff member who was a witness in the incident, who alleged that a staff member of the home, physically abused the resident. The HR Manager identified that the allegation of abuse was reported to the licensee via email in May 2020, and that an investigation was completed with abuse not being substantiated. However, they indicated that the incident was not immediately investigated, and that the interviews related to the incident began on in June 2020, 16 days after the email was received.

There was a risk to the resident's safety as the allegation of abuse by a staff member was not immediately investigated.

Sources: A resident's progress notes, investigation notes related to the incident, and interviews with the ADOC, and HR Manager. [s. 23. (1) (a)]

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, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report immediately to the Director in accordance with s. 24 (1) of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

The home's Abuse Policy stated that "mandatory reporting by all persons" meant all persons (ie employees, volunteers, family members, Substitute Decision Makers (SDMs), Power of Attorney (POA), Long Term Care Home Staff, and Long Term Care Home Operators), who have reasonable grounds to suspect the occurrence of any of the following events, either presently or in the near future are legally obligated to immediately report the suspicion and the information upon which it is based to regulatory bodies, and events included improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident; and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

The HR Manager identified that they received an email by a staff member who alleged an abuse of a resident by another staff. They identified that Head Office received the email in May 2020, but a CIS report was not submitted. A review of the CIS reporting database identified that there was no report related to the incident, and the Administrator verified the same.

Sources: MLTC Complaint Intake, a resident's progress notes; the home's "Abuse Free Communities- Prevention, Education and Analysis" Policy, last revised July 2016, LTChomes.net, and interviews with the ADOC, and HR Manager. [s. 24. (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 to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #3: 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,
(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 a resident's pressure ulcer was assessed at least weekly by a member of the registered nursing staff.

The resident's progress notes identified that they had multiple skin breakdown which started on an identified date, and lasted until they passed away a month later. The resident's wounds continued to deteriorate.

The wound assessment records on Point Click Care (PCC) identified that the resident had a pressure ulcer on a specific location that had opened up, and it was measured initially; however, it was not measured again, in a span of three weeks, up to the time of their death.

The home's policy identified the focus of the home's skin care program was on promoting skin integrity including weekly assessment of areas with altered skin integrity.

RPN #109, who is the home's Skin Care Coordinator identified that pressure ulcers were assessed on a weekly basis.

The ADOC verified that there were no weekly skin assessments for the resident after the initial assessment, and that weekly assessments should have been completed.

There was actual harm associated, as the lack of a weekly assessment prevented the reassessment of interventions or treatments, to prevent further deterioration of the wound.

Sources: A resident's progress notes, wound assessments, the home's "Skin Care Program Overview" Policy, last revised December 2017, and interviews with RPN #109, and ADOC. [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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident was documented.

A review of the home's Complaint Binder under form titled "Log of Verbal Complaints Resolved in Less Than 24 Hours", a complaint was documented to have been reported on an identified date, by a staff member, to the DOC and Administrator. The nature of the complaint was related to a resident's death and a medication error. The form identified that an investigation was initiated and that concerns were not substantiated. It also identified that a medication error report was completed.

However, a review of the home's Medication Incident Log Binder and interview with the Administrator, identified that no medication incident report was filled out for this particular incident.

Sources: MLTC Complaint Intake, the home's Complaint Binder 2020, the home's Medication Incident Log Binder, and interview with the Administrator. [s. 135. (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 to ensure that every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #5: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's Power of Attorney (POA) was notified of a new medication order.

RPN #109 identified that POA consent related to medication orders were documented in the Physician's Orders form, and/or a resident's progress notes.

The Physician's Orders identified that the resident was ordered a medication for pain in August 2020. However, the POA consent box was not checked.

The resident's progress notes identified no documentation of obtained consent for the medication order.

The home's Medication Incident Log Binder identified that an incident report was filled out related to this medication order. The report indicated that the POA was not informed of a new medication order prior to administering the medication; and that re-education stressing the importance of obtaining POA consent prior to medication administration was completed.

The ADOC verified that POA consent was not obtained for the medication order for the resident in August 2020.

Sources: MLTC Complaint Intake, a resident's progress notes, physician's orders, the home's Medication Incident Log Binder, and interviews with RPN #109, and ADOC. [s. 6. (5)]

Issued on this 8th day of February, 2021

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

Original report signed by the inspector.