Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: June 21, 2023	
Inspection Number: 2023-1384-0003	
Inspection Type: Complaint	
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc.	
Long Term Care Home and City: Chartwell Brant Centre Long Term Care Residence, Burlington	
Lead Inspector Carol Polcz (156)	**Inspector Digital Signature** Carol Polcz, RD
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 18-19, 24-26, and May 1-4, 8, 10, 15, 2023.

The following intake(s) were inspected:

- Intake: #00084082 - IL-NC-10803 - Complaint - Concerns re: personal support services.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

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 necessary.

Rationale and Summary:

a) The care plan in place on April 18, 2023 under an identified focus dated February, 2022, indicated that resident #001 currently used an identified device until they were reassessed. At the time of the inspection, the resident was observed to be using an identified device and was no longer using the initial device. The care set out in the plan had not been revised when the resident's care needs had changed. This was confirmed and corrected by the DOC on April 18, 2023.

b) On April 18, 2023, the physician's orders in the plan of care included an identified intervention for resident #001 as a nursing measure; however, this was not included in the resident's care plan. The care plan was not revised when the resident's care needs had changed and not updated until May 10, 2023. The physician's orders were also changed at this time as per interview with the Clinical Coordinator.

Sources: Clinical record review, observation of resident #001 and interviews with the DOC and Clinical Coordinator.

Date Remedy Implemented: May 10, 2023.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee failed to immediately forward to the Director any written complaint that it received concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

Rationale and Summary:

The home received written complaints via email regarding the care of resident #001 on two identified dates in 2022; however, the licensee failed to immediately forward these complaints to the Director as confirmed during interview with the Administrator and DOC and a search on the Critical Incident System.

Sources: Interview with the Administrator and DOC and electronic search on the Critical Incident System on the Long-Term Care Homes Portal.

WRITTEN NOTIFICATION: Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)

The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any.

Rationale and Summary:

As of the date of the inspection, the annual care conference for resident #001 had not taken place as confirmed in record review and during interview with the DOC and Social Services Worker.

Sources: Clinical record review and interview with the DOC and Social Services Worker.

WRITTEN NOTIFICATION: Non-compliance with: O. Reg. 246/22, s. 38 (1) c)

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (1) (c)

The licensee failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included an offer of an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment was required.

Rationale and Summary:

As of the date of the inspection, the annual offer of the annual dental assessment and other preventative dental services for resident #001 had not taken place as confirmed during interview with the DOC and Social Services Worker.

Sources: Clinical record review and interview with the DOC and Social Services Worker.

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (2)

The licensee failed to ensure that each resident received assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care.

Rationale and Summary:

The plan of care for resident #001 indicated that they required total assistance with oral care and extensive to total assistance with eating depending on how they were feeling that day.

During three occasions during the inspection the resident was observed not to have received the required assistance with meals as confirmed by observation and interview with PSW staff.

Sources: Dining observations, clinical record review and interview with PSW staff.

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (1)

The licensee failed to ensure that each resident of the home received preventative and basic foot care services including the cutting of toenails to ensure comfort and prevent infection.

Rationale and Summary:

During an interview with the Clinical Coordinator on May 8, 2023, it was reported that resident #001 required specialized services.

In 2022, consent was given for resident #001 to receive specialized services which were provided on an identified date in 2022. Consent was later withdrawn and the resident no longer received the service. The Clinical Coordinator was made aware.

The Clinical Coordinator assessed resident #001's nails on an identified date in 2023 and documented that the resident's toenails were long.

A month later, the services were reinstated and concerns were noted. Routine follow-up was scheduled for every six to eight weeks.

Resident #001 failed to receive preventative and basic footcare services including the cutting of toenails to ensure comfort and prevent infection for several months prior to April 5, 2023.

Sources: Clinical record review, photo from family member, interviews with Clinical Coordinator and footcare nurse.