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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: October 1, 2024

Inspection Number: 2024-1384-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.

Long Term Care Home and City: AgeCare Brant, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 12, 13, 16, 17, 18, 2024.

The following intake(s) were inspected:

- Intake: #00118495 - Critical Incident (CI) 2900-000030-24 related to falls prevention and management.
- Intake: #00120862 - Follow-up to Compliance Order (CO) #001 from inspection 2024-1384-0002 related to Infection Prevention and Control Program.
- Intake: #00120918 - CI 2900-000034-24 related to abuse of a resident by staff.
- Intake: #00122702 - Complaint related to abuse and resident care.

The following intake was completed in this inspection:

- Intake: #00125466 - CI 2900-000039-24 related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1384-0002 related to O. Reg. 246/22, s. 102 (2) (b).

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that the altered skin integrity of a resident was reassessed at least weekly.

Rationale and Summary
A Critical Incident System report was submitted related to abuse where new bruises were discovered on a resident.

The resident's altered skin integrity was not reassessed for two weeks.

The Skin and Wound Care Lead indicated that altered skin integrity issues, including bruises, are to be reassessed every week. They acknowledged that the resident did not and should have had a weekly wound reassessment.

Failing to ensure that the resident's altered skin integrity was reassessed at least weekly by an authorized person placed the resident at risk for potential further altered skin integrity issues that may have required additional treatment and interventions.

Sources: Resident's clinical record and interview with the Skin and Wound Care Lead.

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