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

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Original Public Report

Report Issue Date: April 11, 2024	
Inspection Number: 2024-1384-0001	
Inspection Type: Critical Incident (CI)	
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	
Lead Inspector Sydney Withers (740735)	**Inspector Digital Signature**
Additional Inspector Klarizze Rozal (740765)	

INSPECTION SUMMARY

The inspection occurred on-site on the following dates: March 18, 19, 21, 22, 25-28 and April 2-4, 2024.

The following intakes were inspected:

- Intake 00096174/ CI: 2900-000030-23 was related to a fall resulting in an injury;
- Intake 00098024/ CI: 2900-000035-23 was related to transferring and positioning techniques;
- Intake 00098510/ CI: 2900-000037-23 was related to an injury of unknown etiology; and
- Intake 00108993/ CI: 2900-000011-24 was related to medication management.

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident;

The licensee failed to ensure that the written plan of care for a resident set out the planned care related to medication use and potential for altered skin integrity.

Rationale and Summary

A resident required a specified medication since the time of their admission. Their initial skin assessment indicated they had areas of altered skin integrity when they were admitted to the long-term care home (LTCH). The resident's care plan did not include the potential for altered skin integrity related to the use of the specified medication. The home's skin and wound program required registered nursing staff to include risk factors for skin breakdown and preventative measures to be taken to protect skin integrity in a resident's care plan. The home's Skin and Wound Care Program Lead acknowledged that the resident's care plan was to include a focus

and specific interventions for managing their risk of altered skin integrity.

Failure to set out the planned care related to medication use and altered skin integrity in the resident's written plan of care may have resulted in required interventions not being communicated to staff.

Sources: Resident clinical record, policy 200-08-01 "Skin Care Program Overview" (reviewed June 2023), interviews with the Resident Assessment Instrument Coordinator and Skin and Wound Care Program Lead. [740735]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that the written plan of care for a resident set out clear directions for staff and others who provided direct care to the resident.

Rationale and Summary
A resident required the use of an intervention to maintain their skin integrity. The Kardex directed personal support workers (PSW) to administer the intervention as ordered. The task list in Point of Care (POC) notified PSWs that the intervention was only to be applied by nursing staff. There was no task available in POC for PSWs to document administration of the intervention or order for registered nursing staff to document their application in the treatment administration record (TAR). Staff interviews demonstrated there was inconsistency in staff understanding of who was

to administer the intervention.

Failure for the written plan of care to provide clear direction led to staff uncertainty and may have resulted in gaps in the administration of the intervention.

Sources: Resident clinical record, interviews with PSWs, Registered Practical Nurses (RPN) and a Registered Nurse (RN). [740735]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to comply with the strategy to monitor a resident after their fall.

In accordance with Ontario Regulation (O. Reg.) 246/22, s. 11. (1) (b), the licensee was required to ensure the falls prevention and management program, at a minimum, provided strategies to monitor residents and was complied with. Specifically, staff did not comply with the home's Head Injury Routine (HIR) policy, which was included in the falls prevention and management program.

Rationale and Summary
A resident had a witnessed fall where they sustained a head injury. The resident's electronic medical records (EMR) indicated no HIR was initiated. The Clinical

Coordinator (CC) acknowledged that the resident's HIR was not initiated and that there were no grounds during that incident for an HIR to not be conducted.

Failure to complete the required monitoring posed a potential risk for not identifying and treating the resident's head injury when a HIR was not conducted.

Sources: Resident EMR, HIR, HIR Policy, LTC-CA-ON-200-07-04, revised July 2023, and interview with the CC. [740765]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(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,

The licensee failed to ensure that when a resident exhibited altered skin integrity, they received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument designed for skin and wound assessment.

Rationale and Summary
A) An RPN became aware of a resident's altered skin integrity on a specified date. An initial assessment should have been completed that same day and was not, as indicated by a review of the resident's clinical record and an interview with the RPN.

B) The resident's Substitute Decision Maker (SDM) notified an RPN of the resident's altered skin integrity on a specified date. The RPN was already aware of the skin concern; however, did not assess the resident's skin integrity when the SDM brought forward their concern or verify whether an initial assessment had been completed in the resident's clinical record. They acknowledged that a skin assessment should have been completed when the SDM notified them of the altered skin integrity.

Failure to complete a skin assessment when the altered skin integrity was identified increased the risk of worsened skin integrity, potential for unmanaged pain and a delay in the source of the altered skin integrity being reviewed by staff.

Sources: Investigation notes, complaint letter, resident clinical record, policy 200-08-01 "Skin Care Program Overview" (reviewed June 2023), interviews with RPNs. [740735]

WRITTEN NOTIFICATION: Maintenance Services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee failed to ensure there were schedules and procedures in place for routine, preventive and remedial maintenance. Specifically, interior surfaces of the LTCH such as walls and handrails were not maintained in a good state of repair throughout the home.

Rationale and Summary

During the inspection, the handrails and walls in the hallways and resident rooms throughout each of the seven resident home areas (RHA) were not maintained in good repair. The plastic that the handrails were made of was cracked, missing corner sections and not tight-fitting, with screw tips exposed in several areas. The walls throughout the RHA, resident rooms and the television (TV) rooms, including the doors and walls, were heavily scuffed, with drywall damage, exposed drywall corner beads and cracked wall protectors.

The licensee did not develop written procedures that directed the Environmental Services Manager (ESM) to proactively monitor the condition of the interior surfaces of the LTCH on a routine basis or a remedial plan to address any identified issues in a timely manner. There were no maintenance schedules developed to ensure a designated staff member would be prompted to complete the preventative monitoring of the interior surfaces or an expectation for when the remedial work was to be completed.

According to staff interviews, the wall and handrail damage observed by the inspector has been ongoing over the last two to three years. The ESM was aware of the condition of the specified interior surfaces of the LTCH. They acknowledged there was no remedial plan to address the condition of the wall surfaces in specified resident rooms or throughout the RHAs, as the maintenance team had prioritized painting and wall repairs in resident rooms when there was a resident discharge. The Administrator could not substantiate when they brought forward concerns with the state of the handrails with their corporate team to review capital project funding. The AgeCare Environmental Consultant (EC) acknowledged that an audit to quantify the damaged handrail areas was not completed until the inspector brought forward the concern at the time of this inspection.

The preventative maintenance audits of the interior surfaces of the home completed by the ESM and EC did not include the handrails. The ESM demonstrated audits completed over the last three months across three RHAs and acknowledged that audits for the remaining four RHAs, including audits completed by the EC were discarded and not kept by the LTCH. By not maintaining the preventative maintenance audits for all RHAs, any outstanding areas requiring a remedial plan, for instance the walls within the TV rooms, were not documented for timely follow-up.

Failure to maintain the handrails in good repair increased the risk of resident injury and prevented them from being cleaned and disinfected properly. The condition and appearance of the walls may influence the level of pleasure a resident has within their living space.

Sources: Observations of all RHAs, preventative maintenance audits, email records, interviews with the Administrator, EC, ESM, nursing and environmental staff. [740735]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated September 2023, was implemented.

Rationale and Summary
The IPAC Standard indicated under section 9.1 that routine practices were to be followed in the IPAC program, specifically (d) the proper use of personal protective equipment (PPE), including the appropriate removal and disposal of PPE.

A PSW provided care to a resident without changing their gloves between tasks, resulting in discomfort for the resident. The home's PPE policy and IPAC Lead indicated the PSW was required to remove and discard their gloves between care tasks.

Failure to follow the required routine practices for PPE removal resulted in discomfort for the resident.

Sources: Investigation notes, policy 205-03-05 "PPE" (reviewed November 2023), interviews with the IPAC Lead, PSW and resident. [740735]

WRITTEN NOTIFICATION: Medication Management System

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee failed to ensure a written policy within their medication management system was implemented.

Rationale and Summary
A resident had an order in place for application of a treatment, which populated the

TAR, where registered nursing staff documented treatment administration. A PSW administered the treatment and an RPN signed the TAR indicating the treatment had been administered. The RPN acknowledged that they did not administer the treatment, had not provided it to a PSW to administer and were not aware who had administered it prior to signing the TAR.

The home's medication administration policy required staff to maintain accurate charting on the TAR and ensure the TAR was available when a treatment was completed to verify that resident's rights were followed. An RN indicated if a member of the home's registered nursing staff did not administer a treatment, they should not sign the TAR.

Failure to ensure medication administration practices were followed as per the specified policy resulted in registered nursing staff not administering a treatment as required by the TAR and not ensuring the resident's rights were followed during the treatment administration. The treatment was administered by an unregulated staff member who was not trained to complete this task, which posed a risk of harm to the resident.

Sources: Investigation notes, policy 5.3 "Medication Administration Record" (reviewed June 2023), resident clinical record, interviews with an and RN. [740735]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (i)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,

The licensee failed to ensure that drugs were stored in an area or medication cart exclusively for drugs and drug-related supplies.

Rationale and Summary
A) An observation of a resident's room identified a specified drug located at the resident's bedside.

B) A resident had an order in place for a specified drug.

i) An observation of the resident's room identified a drug located at their bedside, labelled with a different resident's name.

ii) Investigation records identified that the same drug was stored at the resident's bedside for an extended period of time prior to an incident involving the drug. A PSW involved with the medication incident acknowledged that the drug was stored at the bedside at the time of the incident.

Section 6 of O. Reg. 246/22 defined drug as a substance or a preparation containing a substance referred to in clauses (a) through (d) of the definition of "drug" in subsection 1 (1) of the Drug and Pharmacies Regulation Act. The Consultant Pharmacist confirmed the products outlined in examples A) and B) above met the definition of drug as set out in the Drug and Pharmacies Regulation Act. An RPN acknowledged that both drugs should have been stored on the treatment cart in the medication room.

Failure to ensure the drugs were appropriately stored may have led to misuse of the drug and potential for other residents to access the drug.

Sources: Observation of the resident's room, photo65-68, investigation notes,

resident clinical record, interviews with the Consultant Pharmacist, a PSW and RPN. [740735]

WRITTEN NOTIFICATION: Administration of Drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (ii)

Administration of drugs

s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,

(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,

(ii) a personal support worker who has received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home, who has been assigned to perform the administration by a member of the registered nursing staff of the long-term care home and is under the supervision of that member in accordance with any practice standards and guidelines issued by the College of Nurses of Ontario, and who,

(A) meets the requirements set out in subsection 52 (1) or who is described in subsection 52 (3), or

(B) is an internationally trained nurse who is working as a personal support worker. O. Reg. 66/23, s. 28 (1).

The licensee failed to ensure that no person administered a drug to a resident in the home unless, where the administration did not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person was, a PSW who received training in the administration of drugs.

Rationale and Summary
A resident had an order in place for a specified drug. While providing care, a PSW administered the drug to the resident which resulted in discomfort for the resident. They indicated they did not receive training on administration of the drug, were not directed by registered nursing staff to apply it and were not aware they were not to apply it. They had been administering the drug to the resident for several months prior to the incident.

Section 6 of O. Reg. 246/22 defined drug as a substance or a preparation containing a substance referred to in clauses (a) through (d) of the definition of "drug" in subsection 1 (1) of the Drug and Pharmacies Regulation Act. The Consultant Pharmacist confirmed the product met the definition of drug as set out in the Drug and Pharmacies Regulation Act. The LTCH did not have written policies, protocols or training in place for PSW drug administration.

Failure to ensure a PSW who did not have training on drug administration did not administer a drug to a resident led to a medication error and harm to the resident.

Sources: Investigation notes, medication incident form, resident clinical record, interviews with the Director of Care, Consultant Pharmacist, a PSW and the resident. [740735]

WRITTEN NOTIFICATION: Administration of Drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (6)
Administration of drugs
s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with

the resident. O. Reg. 246/22, s. 140 (6).

The licensee failed to ensure that no resident administered a drug to themself unless the administration was approved by the prescriber in consultation with the resident.

Rationale and Summary
An observation of a resident's room identified a drug located at their bedside. The resident indicated the product had been brought in by their family to treat pain and that they applied it themself with the support of PSWs. A PSW and RPN acknowledged that they supported the resident in administering the drug.

Section 6 of O. Reg. 246/22 defined drug as a substance or a preparation containing a substance referred to in clauses (a) through (d) of the definition of “drug” in subsection 1 (1) of the Drug and Pharmacies Regulation Act. The Consultant Pharmacist confirmed the product met the definition of drug as set out in the Drug and Pharmacies Regulation Act. They indicated that an order for self-administration of a drug would be required in Point Click Care (PCC). There was no order for the drug to be administered by staff or the resident in PCC.

Failure to ensure administration of the drug was approved by the prescriber may have led to misuse of the drug and a gap in pain monitoring.

Sources: Observation of the resident's room, resident clinical record, interviews with Consultant Pharmacist, a PSW, RPN and the resident. [740735]

WRITTEN NOTIFICATION: Resident Records

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 274 (a)

Resident records

s. 274. Every licensee of a long-term care home shall ensure that,

(a) a written record is created and maintained for each resident of the home; and

The licensee failed to ensure that a resident's written record, specifically skin assessments, were created and maintained.

Rationale and Summary

A resident exhibited multiple skin alterations, which included injuries sustained by a fall. The resident's TAR indicated their skin assessments were completed; however, no skin assessment records over a two-week period were found. During this time, the home was transitioning corporations and staff were to document on paper records as electronic documentation was unavailable.

The CC stated the resident's skin assessments were completed during the specified two-week period; however, staff could not locate the paper records.

Failure to ensure that the resident's written skin assessment records were created and maintained, posed a risk to staff not being updated on resident assessments, identifying the improvement or worsening of skin conditions, and the effectiveness of treatments.

Sources: Resident clinical record, and interviews with the CC and staff. [740765]