Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
Oct 5,6,7,8,14,15,2010	2010-173-2900-02Oct140923 2010-173-2900-02Oct143045 2010-129-2900-13Oct102159	Criticial Incident Inspections Log # H01496, H00413, H00975, Complaint Log # H00450

Licensee/Titulaire
Regency LTC Operating Limited Partnership On.
100 Milverton Drive, Suite 700, Mississauga, Ont., L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée
The Brant Centre
1182 Northshore Blvd, Burlington, Ont. L7S 1C5

Name of Inspector(s)/Nom de l'inspecteur(s)
Lesa Wulff – LTC Inspector #173 – Nursing, Phyllis Hiltz-Bontje – LTC Inspector #129 – Nursing

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct critical incident inspections related to 6 critical incidents.

During the course of the inspection, the inspectors spoke with: Residents, Personal Support Workers, Registered Staff, Director of Care, Administrator, Residents and Families

During the course of the inspection, the inspectors: Reviewed resident clinical health records, policy and procedures, admission information, educational inservices, employee files

The following Inspection Protocols were used during this inspection:
Prevention of Abuse and Neglect Inspection Protocol
Dignity, Choice and Privacy Inspection Protocol.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

11 WN
11 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The licensee has failed to comply with O.Reg 79/10 s.8(1)(b)
8(1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute, or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and
(b) is complied with

Findings:

1. **The staff have not complied with the home's Resident Abuse Policy (LTCE-RCA-E-002-NUR-II-02) with respect to:** all staff are required to report any abuse immediately, the home shall ensure the appropriate police force is immediately notified of any alleged/suspected or witnessed incident of abuse, staff will separate resident and abuser, assess the resident immediately, resident's physician will examine the resident as soon as possible after the incident:

    - Issues for five allegations of abuse were reviewed during this inspection and staff did not immediately report/ investigate all cases of alleged abuse, contact the appropriate police force, separate the resident and the abuser, immediately assess the resident and ensure the physician examines the resident in accordance with the homes policy.

2. **The staff have not complied with the home's Responsive Behaviours Management Policy (NUR-V-14) with respect to:** the development and implementation of a program of prevention/treatment/management and evaluation for those residents, written approaches to care that include screening protocols/assessments/reassessments and identification of behavioural triggers, evaluation of strategies for resident response and effectiveness, evaluate the use of psychotropic drugs for possible reduced dosage or discontinuation of medication and determine possible causes of the behaviour:

    - Issues for two residents experiencing responsive behaviours were reviewed during this inspection. Staff in the home did not develop and implement a program of prevention/treatment/management and evaluation related to written approaches to care that includes identification of behavioural triggers, evaluation of strategies for resident response and effectiveness of treatment, evaluation of the use of drugs administered to manage behaviours and possible reduction of the use of these drugs and determining the possible causes of responsive behaviours in accordance with the homes policy.

3. **The staff have not complied with the home's Complaints Policy (LTC-RCA-E-009) with respect to:** persons making a complaint, either verbal or written are free from reprisal; no retaliation or barriers to service will be experienced by the person or any related party to the person making the complaint:

    - One incident was reviewed during this inspection and staff in the home did not comply with the policies direction of no retaliation or barriers to service being experienced by person making a complaint in accordance with the homes policy.

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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 related to developing a process to ensure that staff are aware of the contents of these policies and their responsibilities in relation to complying, to be implemented voluntarily.

WN #2: The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.19(1)
19(1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Findings:

1. Staff in the home did not protect 5 of 5 residents from abuse while receiving care and services from staff.

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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 related to developing a process to ensure that resident's are not abused or neglected by staff in the home, to be implemented voluntarily.

WN #3: The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.3(1)1
3(1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
(1) Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the residents dignity

Findings:

1. Staff in the home have not treated residents with dignity and respect in the provision of care with respect to honoring resident's choices for bedtime and sleep routines, not ensuring that residents hygiene needs are met, telling residents they are a bother to the staff in the home, and forcing care on a resident.

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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 related to developing a process to ensure that all residents in the home are treated with courtesy, dignity and respect, to be implemented voluntarily.

WN #4: The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.3(1)14
3(1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
(14)Every resident has the right to communicate in confidence, receive visitors of her choice and consult in private with any person without interference.

Findings:

1. During this inspection, it was verified that a resident was denied the right to receive visitors in the resident's area of choice without interference. The concern related to the interactions of the resident's family with staff was not verified, investigated or confirmed by the management of the home. The resident and the resident's family were presented barriers to service as a result of making a complaint in the home.

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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 related to completing an internal investigation of the allegations of intimidation by staff, and resolving concerns related to visitation on the home area, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s20(3)
20(3) Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is communicated to all staff, residents, and residents' substitute decision makers.

Findings:

1. During this inspection, it was noted that residents and substitute decision makers have not been provided with the home's policy for prevention of abuse and neglect. During interview with residents and families, it was stated that these parties were not aware of such a policy and did not know how to obtain a copy of this policy. Resident and family councils have not been provided a copy of this policy and have not received any education or information related to this policy.

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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 related to developing a process to ensure that the homes policy of zero tolerance of abuse is communicated to all staff, residents and substitute decision makers to be implemented voluntarily

WN #6: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.6(1)(c)
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.

Findings:

1. During this inspection, it was noted that several active diagnosis', care needs, preferences were not added to the written plan of care for several residents in order to give clear direction to staff providing care.

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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 related to developing a process to ensure that the written plan of care for each resident sets out clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily

WN #7: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s76(2)4
76(2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
(4) The duty under section 24 to make mandatory reports.

Findings:

1. Staff in the home have not received training related to duties under Section 24 of the Long Term Care Homes Act to make mandatory reports.

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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 related to ensuring all staff receive training on the duty to make mandatory reports, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10 s.41
Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Findings:

1. An identified resident during interview on Oct 6, 2010 indicated that she is not provided choice with her bedtime routine. The resident stated "staff comes with my nightgown, and I just go to bed.
2. Staff during interview in October, 2010, were asked if residents are able to choose their own bedtimes. The staff indicated "yes", they are allowed to choose their bedtimes. When questioned further, the staff then stated that all residents were expected to be in bed before 10pm, before night shift begins, so resident rounds can be conducted.

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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 related to developing a process to ensure that residents preferences related to bedtime is supported and documented on the plan of care, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10 s.53(1)1,2
53(1) Every licensee of a long term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
(1) Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental, or other.
(2) Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Findings:

1. An identified resident admitted to the home with existing behaviours, has not been assessed, behavioural triggers identified and strategies implemented to minimize the behaviours and risk to the resident and others. Behaviours continue to be ongoing without reassessment; staff have used medication to manage these behaviours without evaluating the effectiveness of the interventions or changing the plan of care in response to changing needs of the resident.
2. An identified resident with ongoing behaviours has not been assessed, behavioural triggers identified and strategies implemented to minimize the behaviours and risk to the resident. Several episodes of behaviour noted for this resident were in relation to care needs not identified or provided. The resident received a medication to reduce and manage behaviours as a result of staff not relating the behaviour to a care need.

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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 related to developing a process to ensure that written approaches to care include identification of behavioural triggers, techniques and interventions to prevent, minimize responsive behaviours, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10 s.97(2)
The licensee shall ensure that the resident and the resident's substitute decision maker, if any, are notified of the results of the investigation required under subsection 23(1) of the Act, immediately upon completion of the investigation.

Findings:

1. During interview with the Administrator and Director of Care on Oct 7, 2010, management indicated that communication related to results of any internal investigation would be communicated with POA only when the resident is unable to communicate or understand this information.
2. Two identified residents did not receive the results of an investigation related to reports of abuse and rough handling and intimidation. These results were communicated only to the POA (Power of Attorney) of the resident in spite of the fact that both residents were able to respond to questions during interview and recall events.

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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 related to developing a process to ensure that residents as well as substitute decision makers are notified of the result of an investigation immediately upon completion, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10 s.98
Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed, incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal office

Findings:

1. During this inspection, 4 of 5 incidents of alleged abuse reviewed, the police were not called and informed of events that had occurred as per the policy of the home.
2. During interview with the management of the home, it was indicated that the home would contact the police in all cases of alleged abuse to determine if a criminal offence had occurred.
3. During interview with the management of the home, this did not occur in at least two cases, as the families of the home had stated that they were happy with the internal investigation conducted.

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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 related to developing a process to ensure that police are notified immediately of all alleged abuse in the home, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Lisa Wulff
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Apr 27/11