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 22, 2020	2019_556168_0025	020133-19, 020139-19	Complaint

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

LISA VINK (168)

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 5, 6, 9, 10, 11 and 13, 2019 and off site January 14, 2020.

This inspection was conducted concurrently with Critical Incident (CI) Inspection 2019_556168_0026.

This inspection was completed for complaint logs:
020139-19 - related to nursing and personal support services; and
020133-19 - related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), registered nurses (RN), registered practical nurses (RPN), the Program Manager, the acting Assistant Director of Care (ADOC), the scheduler, personal support workers (PSW), a physician, a family member and residents.

During the course of the inspection, the inspector observed the provision of care and reviewed relevant documents including clinical health records, investigative notes, records from the hospital and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff involved in the care of the resident collaborated with each other so that their skin and wound assessments were integrated, consistent with and complemented each other.

Resident #010 fell on an identified date in July 2019, and sustained an injury, which required an intervention, prior to their return to the home on an identified date in August 2019.

On the day of readmission, to the home, until an identified date in September 2019, an area of altered skin integrity was assessed at least 13 times by registered staff, according to the clinical record.
A review of the documented assessments noted interventions completed as well as changes to the area.
The written assessments were not consistent with their assessment findings and did not complement each other related to the findings and interventions completed.

A review of Point of Care (POC) records for Skin Observations conducted by PSW staff for approximately five weeks beginning on an identified date in August 2019, included approximately 60 enteries that there were no areas of altered skin integrity, approximately 60 enteries that the resident's skin had discoloration, an additional 15 enteries which noted a red area and that none of the areas were "new".

The home conducted an internal investigation into an allegation of an incident which was reported by the SDM to have resulted in an area of altered skin integrity. The management of the home received written statements from five PSW staff, during the identified time period, who reported that they did not note any recent changes to the

resident's skin.

Interview with RPN #113, who routinely provided care to the resident, including wound care, on the date prior to the report of the incident and the date following, identified that the resident did not have any change in assessment findings from previous assessments.

Interview with RPN #118, with additional training in Skin and Wound Care, reviewed a number of the skin assessments completed by registered staff and identified that the assessments should have been accurate and comprehensive, noting that the assessments did not include a description of the area, that the information was not consistently recorded as reported by staff and noted a repeated intervention which was only conducted once.

Interview with the Administrator identified that they had reviewed the skin assessments and their plan to review the documents with the staff who completed the assessments as well as for auditing activities related to skin and wound assessments to be reinstated.

Staff involved in the care of the resident did not collaborate with each other so that their skin and wound assessments were integrated, consistent with and complement each other. [s. 6. (4) (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 staff involved in the care of the resident collaborate with each other so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present for a shift.

Chartwell Brant Centre Long Term Care is a long term care home with a licensed capacity of 175 beds.
The DOC verified the front line staffing pattern for the home included at least one RN on duty and present at all times, in addition to a mix of RPNs and PSWs to meet the nursing and personal care needs of residents.
Interview with the acting ADOC and DOC identified that due to recent recruitment efforts they had a sufficient number of RNs on staff to fill all RN positions according to the staffing plan; however, there were occasions when vacant shifts needed to be filled.
It was identified that the home consistently offered additional shifts and overtime to their RNs to replace these vacant shifts; however, when the RNs employed by the home were unwilling or unable to work, the vacant shifts were filled with RNs employed by an employment agency, with the ADOC or DOC onsite.
The Registered Nurses Staffing Schedules were provided for a period of approximately three months in 2019, on request.
It was identified that the home did not have an RN, who was an employee of the licensee and a member of the regular nursing staff, on duty and present on an identified shift.
On the identified date, the charge RN received a sick call, from RN #125, which they replaced with an agency RN.
As per the acting ADOC, on the identified date, they were notified by the charge RN that the shift had been replaced and due to miscommunication the acting ADOC was not present in the home during the identified time period.
It was verified by the DOC that the agency RNs, that worked on the identified shift, were not members of the regular nursing staff.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

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 there is at least one registered nurse who is an employee of the licensee and is a member of the regular nursing staff is on duty and present in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 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 applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was in compliance with and implemented in accordance with applicable requirements under the Act.

The licensee failed to ensure the policy in the required Skin and Wound Care program was in compliance with the requirements of the Act.

In accordance with O. Reg. 79/10, s. 48(1) 2 the licensee was required to have an interdisciplinary Skin and Wound Care program and in accordance with O. Reg. 79/10, s. 50(2)a , the licensee was required to ensure that a resident, at risk of altered skin integrity, received a skin assessment by a member of the registered nursing staff, upon any return of the resident from the hospital.

The home's policy 08 - Skin Care Program Overview, December 2017, identified under the procedure that "Registered staff will complete a skin assessment using the Skin - Initial Skin and Wound Assessment in Point Click Care: on any readmission from the hospital".

Interviews with RPN #112 and #118 each identified that skin assessments were completed only on readmission from hospital and not for cases such as emergency room visits.

A review of the clinical record for resident #010 identified that they were sent to the hospital, for assessment, due to a change in condition and returned to the home approximately ten hours later. The clinical record did not include documentation of a skin assessment on return from hospital.

The Skin Care Program Overview was not in compliance with the regulation. [s. 8. (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 where the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is in compliance with and implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #4: 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident, by anyone, that may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Resident #010 had an intervention, following an incident, with injury, on an identified date in July 2019, and returned to the home on an identified date in August 2019.
The resident required a level of assistance for their activities of daily living, utilized a specified mobility device and an intervention for falls prevention and management.

Meeting notes, written by the Administrator, following a discussion with the Substitute Decision Maker (SDM), on an identified date in August 2019, included documentation that the SDM had concerns regarding an interaction between a specified staff member, the SDM and the resident.
The concerns included issues with the condition of the intervention; the conduct of the staff member towards the SDM and the actions of the staff member when demonstrating the intervention utilized by the resident.
Progress note, by RPN #106, on an identified date in September 2019, identified that the resident was assessed and transported to the hospital for symptoms and a change in condition. This change in status was identified approximately three days after the interaction with the staff member.
Progress note, by RN #108, later that day, identified that the resident returned from the hospital and that the SDM voiced complaints to the RN and RPN #109 regarding a specific incident that occurred at the home, which was then communicated to the management of the home.
Interview with RN #108 identified that their conversation with the SDM on the identified date, included that the SDM reported their concerns regarding the interaction to external care providers who suggested that the incident could have been the cause for the change in condition.
The RN spoke with both the acting ADOC and the Administrator later the same day regarding the concerns.
Interview with RPN #109 regarding the conversation with the SDM identified that the SDM reported that in their opinion the staff members demonstration of the intervention caused the change in condition.
Hospital notes faxed to the home identified an assessment finding.
Meeting notes, written by the Administrator, following a discussion with the SDM, included documentation that the SDM identified that two external service providers suggested that the change in condition could have been as a result of the interaction with the identified staff member.
A progress note, written by the attending physician, identified that the SDM approached them regarding the incident with an identified staff member and that the physician spoke with the Administrator who would follow up with the SDM regarding the incident.
Interview with the attending physician, identified that to their recall the SDM did not use the word "abuse" in discussing the incident, but noted that they were concerned enough to report the incident to them.
Interviews with the SDM of resident #010 identified that they had told numerous individuals about the incident in the home which involved the identified staff.
A review of the Critical Incident System (CIS) did not include a report of the allegation of

abuse as confirmed by the Administrator.
The Administrator identified that they did not report the concerns, to the Director, raised by the SDM as in their opinion they were focused around the treatment of the SDM by the identified staff member and not related to the handling of the intervention.
The Administrator identified that they followed the "Abuse Decision Tree", which was previously distributed by the Ministry, in making their decision to not report and for this reason, based on the internal investigation conducted by the home, did not feel that the home had reasonable grounds to suspect that abuse of the resident occurred.
The Administrator confirmed that they had previously received the "Reporting Requirement Tip Sheet", distributed in 2019; however, this document did not identify that the home was no longer to follow the Abuse Decision Trees, previously released and for this reason did not report the allegation.

The licensee did not report the suspicion of abuse to the Director. [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 the person who has reasonable grounds to suspect that physical abuse of a resident by anyone may occur, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records

Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act.
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1); O. Reg. 451/18, s. 4.

Findings/Faits saillants :

1. The licensee failed to ensure that a record was kept for each RN staff member of the home that included verification of the staff member's current certificate of registration with the College of the regulated health profession, or verification of the staff member's current registration with the regulatory body governing his or her profession and the results of the staff member’s police record check under subsection 75 (2) of the Act.

Ontario Regulation 79/10 section 215(1)(2) identifies that the section applies where a criminal reference check is required before a licensee hires a staff member, as set out in subsection 75(2) of the Act and that the criminal reference check must be conducted by a police force and conducted within six months before the staff member is hired by the licensee.

Subsection 75(3) of the Act identifies that a staff member who is agency staff is considered hired when he or she first works in the home.

It was identified by the acting ADOC and the DOC that the home had a staffing plan and a minimum staffing level that they would maintain to provide care and services to the residents.
When the home was unable to achieve this level, with staff employed by the home, they utilized the services of an employment agency to provide professional nursing services

on request.
There was a contract between the home and Life Line Staffing Services Inc. that identified that the agency would ensure appropriate background checks in respect to any worker were completed, including a criminal reference check and vulnerable sector screening and that any RNs assigned as temporary workers were registered in good standing with the College of Nurses (CNO).
Agency RNs #126, #127 and #128 all worked at the home and were responsible to provide direct care to residents, on one or more shifts, during a three month period of time in 2019.
Interview with the acting ADOC and the Administrator confirmed that the home did not have an employee file or similar records for the agency RNs.
Interview with the acting ADOC verified that they did not have a record of the RN's registration/license, nor had they verified the nurse's standing with the CNO by the CNO "Find a Nurse" website, prior to the provision of care and that the home did not have a copy of the identified RN's police record checks.
The home confirmed and obtained written verification of the status of RNs #126 and #127, with the CNO, on an identified date in December 2019, according to records provided and produced a record for RN #128 dated in June 2019, which supported that all of the nurses were "entitled to practise with no restrictions".
Interview with the acting ADOC verified their practice, when they utilized the services of the agency to provide registered nursing staff, was that they did not consistently ensure proof of registration/license with the CNO nor their criminal reference checks, as it was the responsibility of the agency as outlined in their contact. [s. 234. (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 record is kept for each RN staff member of the home that includes verification of the staff member's current certificate of registration with the College of the regulated health profession, or verification of the staff member's current registration with the regulatory body governing his or her profession and the results of the staff member's police record check under subsection 75 (2) of the Act, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments and the resident's responses to interventions, following an incident, were documented.

Resident #010 and their SDM were involved in an interaction with an identified staff member on a specified date in August 2019, according to meeting minutes of a discussion between the Administrator and the SDM and progress notes.
Interview with the Administrator identified that they asked the staff to monitor the resident after the interaction.
Interview with RPN #112, who worked the shift following the interaction, verified that they were aware of the incident and confirmed that they assessed/monitored the resident during the shift for any response or change in status.
A review of the clinical record did not include a progress note for the assessment nor the residents response, as confirmed by the RPN.

The assessment and resident's response was not documented. [s. 30. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records

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

(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that, a written record was maintained for each resident of the home and was kept up to date at all times related to photographs taken.

According to the clinical records resident #010 had an area of altered skin integrity, including on two specified dates in August and September 2019.
RPN #106 assessed the area on both dates and communicated to the inspector that they photographed the area and sent the picture to the physician on an identified date in September 2019.
A review of the clinical record did not include a picture of the area as confirmed by RPN #112.
RPN #106 was not able to produce the photo, which was taken on their personal phone, on request.
The substitute decision maker (SDM) for resident #010 alleged that the changes to the area were as a result of an interactions between the resident and an identified staff member.
The home's policy Abuse Allegations and Follow Up, LTC-CA-WQ-100-05-02. effective July 2010, identified the procedure for allegations of physical abuse included to "take pictures of red areas, injuries and other marks ensuring that the resident remains and feels safe. Ideally, pictures should be taken with a digital camera with two copies printed immediately - one copy for the police and one copy for the Home file".

The written record was not maintained and up to date related to the photograph taken. [s. 231.]

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Ministère des Soins de longue durée

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Issued on this 28th day of January, 2020

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

Original report signed by the inspector.