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
May 26, 2020	2020_560632_0006	001307-20, 003475-20	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive MISSISSAUGA ON L5W 0G5

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

YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 11, 12, 13, 2020.

The following Critical Incident System (CIS) inspections were conducted during this inspection:
Log #001307-20 was related to falls prevention,
Log #003475-20 was related to prevention of abuse and neglect, falls prevention, skin and wound care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Social Worker, Physiotherapist, Unit Clerk, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

During the course of the inspection, the inspector(s) reviewed clinical records, policies, procedures, and practices within the home, reviewed meeting minutes, observed the provision of care and medication administration.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that different approaches were considered in the revision of the plan of care.

A Critical Incident (CI) Report was submitted to the Director indicating that resident #002 sustained a fall on an identified date in January 2020, resulting in injury. Post-Fall Assessment and Analysis review indicated the resident performed specified activity before the fall occurred.

Resident #002 was assessed at specified risk for falls. The resident had a history of falls, where previous fall occurred on an identified date in January 2020. Post-Fall Assessment and Analysis review indicated the resident was performing specified activity.

During the inspection, the resident was observed performing specified activity in their room and their bed was not in the specified position and the resident monitoring device was on. During the inspection RPN #105 indicated that the bed was to be in the specified position as a post-fall intervention and the resident had specific directions on the use of the resident monitoring device.

During the inspection, PSW #106, PSW #112 and PSW #113 indicated that the resident's bed was to be in the specified position and provided different answers on the use of the resident monitoring device.

During the inspection, the current resident #002's plan of care contained the same interventions listed in previously revised resident #002’s plan of care. Review of Post-Fall Assessment and Analysis indicated that specified bed was used by the resident with no directions included on its use for the resident.

During the inspection, RPN #111 confirmed that the written plan of care did not contain the interventions related to the use of resident monitoring device and positioning the resident’s specified bed, which was acknowledged by the DOC.

Review of the Policy titled: "Resident Falls Prevention Program" indicated that “…Based on analysis of the fall event, the registered staff with resident and POA input will review and modify the fall prevention care plan to include interventions to prevent repeat falls from occurring based on the root cause of the fall".

The licensee failed to ensure that different approaches were considered in the revision of the plan of care for resident #002. [s. 6. (11) (b)]

Issued on this 27th day of May, 2020

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

Original report signed by the inspector.