Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 9, 2014	2014_344586_0012	H-001135-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

Long-Term Care Home/Foyer de soins de longue durée

BURLOAK
5959 NEW STREET, BURLINGTON, ON, L7L-6W5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JESSICA PALADINO (586), DIANNE BARSEVICH (581), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 26, 27, 28, 29 and September 2, 3, 4, 2014.

The following inspections were completed simultaneously with this Resident Quality Inspection and any areas of non compliance related to these inspections will be included in
this report.
Complaint Inspection: H-000628-14
Critical Incident Inspection: H-000795-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Manager, Program Manager, Resident Services Coordinator, Registered Dietitian, Staff Educator, Resident Assessment Instrument Coordinator (RAI Coordinator), Physiotherapist, registered staff, personal support workers (PSWs), and identified residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed resident care, meal service and medication administration, and conducted a review of the health records for identified residents, relevant policies and procedures, investigation notes completed by the home, and meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure resident #300 was protected from abuse by a co-resident.

According to the clinical record on a specified date in June 2014, and interview with the DOC, resident #300 was found on the floor stating resident #301 had pushed them, and interview with resident #301 by staff confirmed this. Resident #300 complained of significant pain and x-rays ordered by the physician demonstrated the resident sustained an injury. Resident #300 was not protected from abuse by a co-resident. [s. 3. (1) 2.]

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 resident #300 is protected from abuse, to be implemented voluntarily.

WN #2: 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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee did not ensure that staff and others involved in different aspects of care of the resident collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent with and complemented each other.

Resident #003's treatment record indicated that the resident had an abrasion and a lesion to a specified area on their body and the progress notes indicated that the resident had an abrasion to this area. The dietary referral that was sent to the RD on a specified date in March 2014, indicated that the resident had a skin tear to this area. The head-to-toe skin assessment that was completed on a specified date in March 2014, indicated that the resident had a pressure area, and the Resident Assessment Protocol (RAP) assessment completed on a specified date in March 2014, indicated that the resident had a staged pressure ulcer to this area. The ADOC confirmed that the assessments were not consistent and did not complement each other. [s. 6. (4) (a)]

2. The licensee did not ensure that the resident, the resident's substitute decision-maker (SDM), if any, and any other persons designated by the resident or SDM were given the opportunity to participate fully in development and implementation of the resident's plan of care.

Resident #101 fell twice on a specified date in March 2014. The home's policy titled "Falls Interventions Risk Management (FIRM) Program" (revised April 2013) stated that a resident's SDM was to be notified of all falls. The SDM for the resident stated that they did not receive a call to inform them of the falls until one day after the incidents. Review of the resident's clinical health records indicated that a registered staff member attempted to call the SDM after the first fall on the same date it occurred; however, there was no answer and they did not leave a voice message. Review of the meeting notes between the SDM, DOC, and the registered staff member from a specified date in May 2014, indicated that the staff confirmed no voice message was left. Interview with the DOC on September 3, 2014, confirmed a voice message should have been left to inform the family of the two falls. [s. 6. (5)]

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 staff and others involved in different aspects of resident #003's care collaborate with each other in the resident's assessment so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee did not respond in writing within ten days of receiving Family Council advice related to concerns or recommendations.

A review of the Family Council Meeting Minutes from October 2, 2013, demonstrated that a concern was brought forward regarding the sausages on the dinner menu being too salty. This concern was not responded to by the Food Service Manager in writing until October 29, 2013. Interview with the Family Council Assistant and the Administrator confirmed that the written response to the concern was not completed within ten days. [s. 60. (2)]

Issued on this 9th day of September, 2014

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