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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Jun 1, 2015	2015_343585_0011	H-002423-15	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

LEAH CURLE (585), CYNTHIA DITOMASSO (528), LISA VINK (168)

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): May 7, 8, 11, 12, 13, 14 and 15, 2015.

The following inspections were completed concurrently with this Resident Quality Inspection (RQI): four Critical Incident Systems (CIS) H-001457-14, H-002044-15, H-002003-15, H-002219-15, and one complaint H-001865-15.

Any findings of non compliance identified during the identified concurrent inspections are included in this RQI report.

During the course of the inspection, the inspector(s) spoke with residents, families, the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), the Environmental Manager (EM), Food Services Manager (FSM), Program Manager, Resident Services Coordinator, Resident Assessment Instrument (RAI) Coordinators, Registered nursing staff, Personal Support Workers (PSWs), dietary, housekeeping and laundry staff.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical health records, policies and procedures, meeting minutes, logs, menus and recipes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

8 WN(s)
4 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	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. 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A) The plan of care for resident #09 identified that the resident's hearing was impaired and directed staff to try and eliminate background noise and to face the resident when speaking, making eye contact. Minimum Data Set (MDS) assessments from November 2014 and February 2015 identified that the resident had no hearing impairment; however, MDS assessments prior to November 2014 identified the resident's hearing was impaired. Interview with the Resident Assessment Instrument (RAI) Coordinator confirmed that the MDS assessment for hearing patterns, from November 2014 and February 2015, were incorrect as the resident had a significant hearing impairment. The MDS assessment was inconsistent with the assessments completed by direct care staff as outlined in the written plan of care. (528)

B) The plan of care for resident #11 identified that the resident required two half rails when in bed for bed mobility. The annual MDS assessment from February 2015, identified that other types of side rails (including half rails) were not used by the resident. Interview with the RAI Coordinator and a Registered Practical Nurse (RPN) confirmed that the MDS assessment from February 2015, was a coding error and the resident used half rails daily. The MDS assessment from February 2015 did not complement the written plan of care. [s. 6. (4) (a)]

2. The licensee failed to ensure that when the resident was reassessed, the plan of care was reviewed and revised at least every six months and at any other time when the the care set out in the plan was no longer necessary.

Upon admission to the home, resident #23 had two altercations with co-residents. As a result of the new behaviours, various interventions were implemented including but not limited to: one to one monitoring, re-orientation and redirection, distraction, and proactive schedule to limit free time. Review of the plan of care included a schedule, created by Behavioural Supports Ontario (BSO) to keep resident busy. Interview with registered staff confirmed that the resident was no longer on one to one monitoring and a set schedule was no longer necessary; instead staff continued to keep the resident distracted and included in programs to keep busy. The plan of care was not updated when the care set out in the plan was no longer necessary, related to responsive behaviour interventions. [s. 6. (10) (b)]

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 and ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident 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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

In May 2015, five secure outdoor terraces were observed being accessible to residents. Staff in the home reported the areas were used by residents. Each area was not equipped with a resident-staff communication and response system, which was confirmed by the Administrator. [s. 17. (1) (e)]

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 and ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that their written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy, "Resident Non-Abuse - Ontario, LP-C-20-ON", last revised September 2014, noted that "any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director of the Home or, if unavailable, to the most senior Supervisor on shift at that time."

In the fall of 2014, a Personal Support Worker (PSW) reported to their supervisor that they witnessed, what they believed to be abuse of a resident, by a co-worker approximately one week before. The PSW, who witnessed the incident confirmed that they did not report the incident of abuse immediately and was aware of the expectation to do so, based on training provided by the home. The staff member did not comply with the home's policy in relation to the requirement to report all suspected or actual abuse immediately, as confirmed during an interview with management staff. [s. 20. (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 and ensure that their written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure all foods were prepared, stored, and served using methods which preserve appearance.

Puree foods were observed on multiple days as runny in consistency and did not look visually appealing. These items included:

i) Ham and two salads, served May 7, 2015 for lunch.
ii) Carrot, served May 8, 2015 for lunch.
iii) Banana, served May 13, 2015 for breakfast.

A cook and the Food Service Manager (FSM) confirmed puree items should be prepared to a pudding thick consistency and hold their shape throughout meal service. Both reported that puree foods were prepared to an appropriate consistency in the kitchen; however, at times, had experienced some items not maintaining appropriate consistency through meal service. Both also reported that runny puree foods were hazardous as they could increase the risk for choking. [s. 72. (3) (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 and ensure that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was protected from abuse by anyone.

In the fall of 2014, resident #04 was not protected from abuse. The resident had a history of responsive behaviours and was known to be resistive to care at times. An allegation of abuse was reported and employee statements and an internal investigation identified that during the provision of care, the resident demonstrated responsive behaviours and was physically resistive towards staff. The PSW responded to the behaviours by speaking to the resident inappropriately, striking out and providing rough care, to which the resident responded "ow that hurt". The resident was not protected from abuse. (168) [s. 19. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

A) In February 2015, resident #23 had two altercations with co-residents. As a result of the incidents, new interventions were initiated, which included but were not limited to: Dementia Observational System (DOS) charting and referrals to BSO for Psychogeriatric Assessment. A review of the DOS charting for the seven day observation period revealed the behaviours were not consistently documented for four out of the seven days. Interview with registered staff confirmed that the resident's behaviours were not consistently documented on four out of the seven observation days. (528)

B) Resident #04 had a history of demonstrating responsive behaviours, which included resistance to care. In May 2015, a change was made to the resident's antipsychotic medication dose. Registered staff reported documentation to monitor the response to the change included completion of DOS charting, as well as a clinical progress note for each shift. Both items were reviewed and revealed incomplete documentation of the resident's response to the change. This was confirmed by registered staff. (585) [s. 53. (4) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

In May 2015, resident #30 was observed on two occassions receiving total assistance from staff with eating, with presence of head hyperextension and poor head control. On one occassion, the resident was observed coughing without sound and demonstrated facial signs of discomfort. The RN confirmed the presence of hyperextention, stated the resident required a change in position to prevent risk of aspiration, and proceeded to adjust the resident to a safer feeding position. [s. 73. (1) 10.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

Resident #10 identified that they had a lost a watch in October 2014. A review of the resident's clinical progress notes during this time included an entry that indicated they were missing a watch. Interview with the registered staff confirmed knowledge of the missing watch, and that it was found approximately one month later. A review the Concern/Complaint/Compliment Log for 2014-2015 did not include an entry for the identified missing item.

The Resident Services Coordinator was interviewed and unable to locate a report of the missing watch in the home's Client Services Response (CSR) folder. It was an expectation that a CSR form be completed for all missing items, with the exception of clothing, and forwarded to the Resident Services Coordinator's attention as they maintained the Concern/Complaint/Compliment Log, which was generated in part from CSR reports. As a CSR was not completed, the item was not included on the log, which would have included the required information. The Resident Services Coordinator confirmed that a documented record was not in place regarding the missing item as required. [s. 101. (2)]

Issued on this 19th day of June, 2015

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

Original report signed by the inspector.