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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Nov 8, 2016	2016_322156_0014	030942-16	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

CAROL POLCZ (156), LESLEY EDWARDS (506), 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): October 25, 27, 2016

During the course of this inspection the following inquiries were conducted on-site:
Complaint 29954-16 - related to staffing
Critical Incident 35035-15 - related to falls prevention
Critical Incident 3882-16 - related to falls prevention
Critical Incident 2589-15 - related to lifts and transfers
Critical Incident 8765-16 - related to medications

During the course of the inspection, the inspector(s) spoke with Administrator, Director of CAre (DOC), Acting Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Back-up RAI Coordinator, registered nursing staff, personal support workers (PSW's), Food Services Manager (FSM), family members and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (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 the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) The plan of care for resident #002 identified that they were on an identified therapy and if an un-witnessed fall occurred and/or head injury was suspected, staff were to send the resident to the hospital. The resident sustained a fall in October 2016. According to the clinical record the fall was un-witnessed, the resident sustained injury. Interview with registered staff #109 verified that she assessed the resident immediately post fall, treated the injury and initiated a head injury routine. The resident did not demonstrate symptoms of a head injury and for this reason was not transported to the hospital. Registered staff #109 and #108 verified that there was a recent change in the home's expectations related to un-witnessed falls and residents on the identified therapy and that decisions made to transport any resident to the hospital post fall would now be made based on the assessment findings and not just if the fall was un-witnessed and the resident was on the identified therapy. Registered staff #109 and #108 verified that the plan of care was not revised when the care set out in the plan of care was no longer necessary.

B) The plan of care for resident #002 identified that they used bed rails in the raised position for positioning and bed mobility. Progress notes of September 2016, identified that the resident was reassessed and that the Substitute Decision Maker (SDM) consented to the resident utilizing a number of fall prevention strategies including the bed rails to be in the down position, fall mats at the bed side and the bed rails in the down position. An observation of the resident's bed system on October 27, 2016, identified that the bed rails were secured to the bed frame and could not be raised. Interview with registered staff #101 and #108 verified that the resident no longer used bed rails in the raised position. A review of the plan of care with registered staff #108 verified that the plan was not reviewed and revised related to bed rail use when the care set out in the plan of care was no longer necessary. [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 to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessar, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident safety risks.

Observation of resident #002 and #005's bed systems identified that they had a mattress on their bed with raised sides. Interview with the DOC and registered staff #101 and #108 verified that the residents had a mattress with raised sides, indicated that the home referred to these surfaces as "bolstered" mattresses and that although the home had a significant number of these mattresses they were not the only style available for use. A review of the plans of care did not include an assessment of the residents with respect to the use of the bolstered mattresses, nor did it identify if the surface supported the residents with an activity of daily living, restricted their movement out of bed or any other safety risks associated with the use of the device. The use of the bolstered mattress was not included in either of the resident's plan of care. Interview with the DOC and registered staff #101 verified that the home did not assess residents for the use of bolstered mattresses, other than based on their cognitive status and that the plans of care were not based on an assessment of the residents safety risks. [s. 26. (3) 19.]

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 plan of care was based on an interdisciplinary assessment with respect to the resident safety risks, to be implemented voluntarily.

Issued on this 24th day of November, 2016

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

Original report signed by the inspector.