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
Feb 3, 2020	2020_820130_0004	014907-19, 014962-19, 021508-19, 000303-20	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

GILLIAN HUNTER (130), CATHY FEDIASH (214)

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): January 15, 16, 20, 22 and 23, 2020.

During the course of the inspection, the inspector(s) toured the facility, observed residents and resident care, reviewed relevant resident clinical records, investigation notes, critical incident reports, staff education reports and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), the Associate Director of Care (ADOC), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents and families.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee failed to ensure that the plan of care for resident #003, set out clear directions related to a specific task, to staff and others who provided direct care to the resident .

A) The plan of care for resident #003, specifically the Quarterly Resident Assessment Instrument (RAI) Minimum Data Set (MDS) Assessment completed on a specific date in 2019, indicated the resident required a specific level of assistance with an identified task during the seven day observation period. The Resident Assessment Instrument (RAP) summary completed during the same assessment period indicated the resident required a different level of assistance with the same task. The narrative care plan reviewed and revised on an identified date in 2019, was consistent with the RAP summary statement; however, the narrative care plan nor the RAP summary statement specified clear direction to staff when or under what circumstances the resident would require the specified level of assistance.

On an identified date in 2019, the home submitted a CI, describing an incident whereby on an identified date in 2019, resident #003 was reported to have sustained a fall during specific care.

It was confirmed during the record review and interview with the ED that the plan of care for a specific task did not provide clear direction to staff providing care. [s. 6. (1) (c)]

WN #2: 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 :

The licensee failed to ensure that resident #004 was protected from abuse by staff #106.

O. Reg. 79/10, s. 2(1) defines emotional abuse as any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A Critical Incident submitted on an identified date in 2020, described an incident whereby, on a specified date in 2020, PSW #107 witnessed an incident between agency PSW #106 and resident #004. According to the clinical record, the resident had a specific diagnosis and a history of responsive behaviours.

Interviews conducted with the Administrator and PSW#107, as well as investigation notes confirmed that on the identified date in 2020, resident #004 was emotionally abused by PSW #106. [s. 19. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee failed to ensure that staff #102 used safe transferring and positioning devices or techniques when assisting resident #101.

The home's policy titled: ENT - Resident Safety, CARE10-P10, reviewed in 2019, included specific instructions regarding the use of specific devices.

The plan of care for resident #001, indicated the resident had a specific diagnosis and required assistance with a specific task at specific times.

On an identified date in 2019, the home submitted a CI, which described an incident whereby on a specified date in 2019, resident #001 sustained a fall while receiving assistance from staff #102.

Interviews with the ED, staff #102, documentation and video surveillance confirmed that staff #102 did not comply with the home's policy and use safe transferring devices and techniques when providing assistance to resident #001.

Issued on this 3rd day of February, 2020

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

Original report signed by the inspector.