Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 11, 12, 13, 28, Sep 23, Oct 14, 2011	2011_070141_0011	Complaint

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

SHARLEE MCNALLY (141) Richard Hayden (127) [signature] 11/28/11

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, registered nursing staff, personal support workers, laundry staff, and resident's family

During the course of the inspection, the inspector(s) reviewed the residents' records, home's complaint log, observation of residents' care, meals and medication administration, and inspection of residents' bed linens.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Continence Care and Bowel Management

Critical Incident Response

Dining Observation

Falls Prevention

Medication

Personal Support Services

Responsive Behaviours

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. 6. Plan of care
Specifically failed to comply with the following subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The plan of care for identified does not set out clear directions to staff who provide direct care to the resident.
The resident was identified by staff as using a therapeutic intervention daily when up. The plan of care did not include the need for this intervention.
The resident's eyes needed daily cleaning because of crusting. The plan of care did not include the need to clean residents eyes daily. s.6.(1)(c)
2. The plan of care for identified resident did not set out clear direction to staff who provide direct care to the resident related to risk of falls. The resident, after sustaining multiple falls, had a bed/chair alarm initiated and a front fastening seat belt latched when up in her wheelchair. The resident was observed during the inspection period with both pieces of equipment in the place. The resident's plan of care did not include these interventions or care needs required related to the use of the equipment. s.6.(1)(c)
3. The plan of care for an identified resident did set out clear direction to staff who provide direct incontinence care for the the resident. The resident had frequent, loose bowel movements. The resident's plan of care did not direct staff in monitoring, documentation and care needs to be provided specific to this need. Staff have not recorded resident's frequency of bowel movements in the resident's daily flow sheets.

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 all residents' plans of care provide clear directions to staff who provide direct care to the resident,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service
Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The homes linen is not consistently clean, free from stains, and maintained in a good state of repair. Inspection of linen on residents' beds in July, 2011 identified examples of worn, thin, torn and stained fitted sheets and mattress pads. There was also observation of residents' beds missing top sheets or having fitted sheets on the bed in place of a top sheet. r.89.(1)(c)
2. All resident's personal items and clothing are not labeled. Sixteen resident's personal clothing were inspected in July, 2011 and 9 resident's had clothing in their room with no labels. Many articles of residents' clothing were also observed to have labels peeling off. The staff confirmed that the home has initiated a new label product and the label is not adhering to resident's clothing as effectively as previous. Labels have been observed to fall off in the laundry. r.89.(1)(a)(ii)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents
Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee did not inform the Director that an identified resident had an unobserved fall causing injury. The resident was transferred to hospital for further assessment. The Director of Care confirmed that a Critical Incident report had not been completed. r.107.(3)4

Issued on this 28th day of November, 2011

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