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
Dec 15, 2020	2020_560632_0015	011869-20, 011871-20, 011988-20, 012520-20, 016939-20, 023532-20	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

YULIYA FEDOTOVA (632), HELENE DESABRAIS (615)

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): November 12, 13, December 2, 3, 7, 8, 2020.

The following Critical Incident System (CIS) Inspection was conducted:
log #016939-20, #011869-20, #011871-20 and #023532-20 - related to falls prevention,
log #011988-20 - related to prevention of abuse and neglect.

The following Compliance Order Follow Up (FU) Inspection was completed during this CIS Inspection:
log #012520-20 - related to prevention of abuse and neglect.

The following Complaint Inspection # 2020_560632_0019 was completed concurrently with this CIS Inspection:
log #016617-20 - related to staffing.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), acting DOC, Regional Manager, Administrative Clerk, former Pinkerton Security Agent, Pinkerton Managing Director, Physiotherapist (PT), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), housekeeping, residents and their families.

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

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_543561_0005	632

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with s. 24 (1) (2) in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee was vicariously liable for staff members failing to comply with subsection 24 (1).

A review of Critical Incident (CI) Report indicated alleged abuse to resident #001 by staff #121, which was based on audio tape recording dated several days earlier than it was reported to the home by staff #123.

Review of the Burlington Burloak Schedule indicated that on an identified date in May 2020 staff #121 worked in the afternoon shift and staff #123 worked in the morning shift in the home and were providing specified service to resident #001.

Interview with staff #121 confirmed that they had been recorded by staff #123 without their consent on an identified date in May 2020, where staff #121 mentioned about specified activities towards resident #001. Interview with Pinkerton agency's Managing Director indicated that staff #123 did not report the incident of alleged abuse to the agency but reported it to the home on an identified date in June 2020. Interview with the home's ED and the acting DOC indicated that the home was informed by staff #123 about the audio recording on an identified date in June 2020 and on the same date the home informed the Ministry of Long-Term Care (MLTC) via INFOLINE – Long Term Care Homes afterhours system.

Resident #001 was put at risk of harm, when staff #123 failed to report the alleged abuse immediately to the Director.

Sources: MLTC via INFOLINE – Long Term Care Homes afterhours system, CI Report, Burlington Burloak Schedule, interviews with the ED, acting DOC, Pinkerton Managing Director, staff #121. [s. 24. (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 a person who has reasonable grounds to suspect abuse of a resident reports the alleged abuse immediately to the Director, to be implemented voluntarily.

Issued on this 21st day of December, 2020

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

Original report signed by the inspector.