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
Oct 21, 2021	2021_916168_0010	013910-21, 014712-21	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

LISA VINK (168), JENNIFER ALLEN (706480)

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): October 14 and 15, 2021.

This Critical Incident System (CIS) inspection was conducted for the following intakes:
013910-21 - related to continence care and bowel management; and
014712-21 - related to falls prevention and management.

Please note that Director Mike Moodie, shadowed the Inspectors on October 14, 2021, of the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Regional Manager, Director of Care (DOC), Infection Prevention and Control Manager, Registered Nurses (RN), Registered Practical Nurses, Personal Support Workers (PSW), a housekeeper, a screener and residents.

During the course of the inspection, the inspectors toured portions of the home, observed the provision of care and services and reviewed records, including but not limited to, relevant procedures, investigative notes and clinical health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to two residents.

i. A resident returned from the hospital with an intervention in place. The physician was contacted and the intervention was ordered to continue.
Subsequent physician's orders were received related to the intervention prior to it being discontinued.
The orders did not provide clear direction to staff related to the size of the intervention to be used, as confirmed by staff.
Interview with the management confirmed that the staff would follow the physician's orders related to the intervention, including the size and the home generally had at least two sizes of available for use.
The plan of care did not give clear direction to staff.

Failure to ensure that staff were provided clear direction had the potential to place the resident at risk for harm.

Sources: Physician's orders for a resident and interviews with staff.

ii. A second resident had an intervention as noted in an assessment and staff statements.
A review of the physicians orders did not include the size of the intervention to be used, as confirmed by staff.
The plan of care did not give clear direction to staff.

Failure to ensure that staff were provided clear direction had the potential to place the resident at risk for harm.

Sources: Physician's orders for a resident and interviews with staff. [s. 6. (1) (c)]

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

A resident had an intervention as documented in the clinical record.
A Minimum Data Set (MDS) assessment included the use of the intervention.
A second assessment, completed the same day as the MDS Assessment, identified that the resident did not have the intervention.
Staff confirmed that the assessments were not consistent with each other and that the intervention was not identified in an assessment.
The assessments were not consistent with and did not complement each other.

Inconsistent assessments had the potential to place the resident at risk for harm if staff were not aware of the needs of the resident.

Sources: Assessments and progress notes for a resident and a staff interview. [s. 6. (4) (a)] [s. 6. (4) (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 to ensure that the plan of care set outs clear directions to staff and others who provide direct care to residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee failed to ensure procedures included in the required Medication Management System were complied with.

In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to develop an interdisciplinary medication management system and in accordance with O. Reg. 79/10, s. 114 (2) the licensee was required to ensure that policies and protocols were developed for the accurate dispensing of all drugs used in the home.

The home's procedure LTC - Medication Review, identified that the nurse would compare the Physician's Order Review against the resident's current medication administration record, recent physician's order and last Physician Order Review to ensure the document was up to date prior to the physician/prescriber review.
Physician's Order Reviews noted "discontinue all previous orders" which provided direction that once the review was signed by the physician only those orders included on the form were current orders.

A resident had an intervention in place.
A review of their Physician's Order Review and subsequent Physician's Digiorders, did not include any orders for the intervention, as confirmed by staff.
The last order for the intervention, as identified by the Inspector, was in 2020.
Staff did not follow the home's procedure when the orders for the intervention were not included on the Physician's Order Review.

Failure to follow the home's procedure had the potential for risk of harm to the resident if orders were not be in place for required interventions.

Sources: Review of procedure LTC - Medication Review, physician's order and progress notes for a resident and interviews with staff. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee failed to ensure that all staff participated in the implementation of the program related to hand hygiene.

During the course of the inspection, three nourishment passes were observed in two different resident home areas.
During the nourishment passes three staff were observed to serve residents a drink or snack without immediate prior assistance with hand hygiene.
It was observed that two staff did not complete their own hand hygiene before or after the initial resident/resident environment contact.
Discussion with the three staff members confirmed that they had all received training on hand hygiene.

The home's procedures Routine Practices and Additional Precautions identified that the routine practice of hand hygiene was to be used with all residents including before handling or eating food and staff would perform hand hygiene before, between and after activities that may result in cross contamination.

The failure to comply with the home's Hand Hygiene Program presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that might have been on their hands.

Sources: Observations of nourishment passes, review of procedures Routine Practices and Additional Precautions, interviews with staff. [s. 229. (4)]

Issued on this 21st day of October, 2021

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

Original report signed by the inspector.