Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: February 27, 2023

Inspection Number: 2023-1342-0002

Inspection Type:
- Complaint
- Follow up

Licensee: AXR Operating (National) LP, by its general partners

Long Term Care Home and City: Burloak, Burlington

Lead Inspector	**Inspector Digital Signature**
Jennifer Allen (706480)	Jennifer L Allen Digitally signed by Jennifer L Allen Date: 2023.03.02 09:14:19 -05'00'

Additional Inspector(s)
Nishy Francis (740873)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 13 - 15, 17, 21-23, 2023.

The following intake(s) were inspected:
- Intake: #00013276 - Complaint related to no registered nurse in the building, physical abuse of a resident and laundry service
- Intake: #00014386 - FU intake to High Priority CO #02 from inspection #2022_1342_0001, related to O. Reg. 246/22 s. 55(2)(b)(ii), with a CDD of January 27, 2023 (Amended date).
- Intake: #00014384 - FU - High Priority CO #01, issued in the inspection # 2022_1342_0001, FLTCA, 2021 s. 24(1) with the compliance due date December 30, 2022.
- Intake: #00014389 - FU intake to high priority CO #03, from inspection # 2022_1342_0001, related to O. Reg. 246/22 s. 55(2)(b)(iv), with CDD of January 27, 2023 (Amended).

Previously Issued Compliance Order(s)

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The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
FLTCA, 2021	s. 24(1)	2022_1342_0001	CO #01	Nishy Francis (740873)
O. Reg. 246/22	s. 55(2)(b)(ii)	2022_1342_0001	CO #02	Nishy Francis (740873)
O. Reg. 246/22	s. 55(2)(b)(iv)	2022_1342_0001	CO #03	Nishy Francis (740873)

The following **Inspection Protocols** were used during this inspection:

- **Resident Care and Support Services**
- **Skin and Wound Prevention and Management**
- **Housekeeping, Laundry and Maintenance Services**
- **Medication Management**
- **Infection Prevention and Control**
- **Prevention of Abuse and Neglect**

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting To The Director

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that the director was immediately informed of the physical abuse of a resident.

Rationale and Summary

In accordance with FLTCA 2021., s. 28 (1) 2, the licensee is required to ensure a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A Critical Incident Report was submitted to the Director. The report was relating to an alleged physical abuse incident between two residents. The home started the investigation the same day as when the incident occurred. As a result, there was actual harm to the resident's safety and wellbeing, where they sustain an injury.

The Director of Care (DOC) and the Executive Director (ED) confirmed they were aware of the reporting requirement for abuse incident.

By not reporting the alleged incident of abuse immediately to the Director, it may delay actions required to respond to the incidents, which placed residents at risk of harm.

Sources: Record review of the residents and interviews with the DOC and ED.
[706480]

WRITTEN NOTIFICATION: Duty to Protect

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1).

The licensee has failed to ensure that a resident was protected from abuse by another resident.

O. Reg. 246/22, s. 2(1)(b)(c) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

On a specified day, a resident had an altercation with another resident, causing a resident to become agitated and injuring the other resident. The injured resident was assessed by the registered staff, and it was documented that the resident sustained an injury from the altercation. The staff member stated the injured resident was anxious and emotionally upset following the altercation.

The home's Resident Non-Abuse Program stated the home is committed to providing a safe and supportive environment for their residents and has a zero tolerance for abuse and neglect.

The resident's documented Cognitive Performance Score and their Aggressive Behaviour Score a the time of the incident indicated severe cognitive impairment and greater frequency and intensity for aggressive behaviours.

Staff stated the resident had a history of aggressive physical responsive behaviours prior to the incident and after. The ED confirmed the resident had a history of responding with physical aggression.

The home's failure to protect the resident from physical abuse caused a actual harm to the other resident's health and wellbeing.

Sources: Resident Non-Abuse Program (ADMIN1-P10-ENT, Last review March 31, 2022); residents clinical health record and interviews with the DOC and other staff.
[706480]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 60 (a).

The licensee has failed to comply with the home's Responsive Behaviour Procedure Policy

related to determining risk following an physical abuse incident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols were developed for the responsive behaviours program, and to ensure these policies and protocols were complied with.

Specifically, a registered staff did not comply with the Revera's Responsive Behaviour Procedure Policy.

Rationale and Summary

An incident occurred when two residents had an physical altercation, resulting in a resident sustaining an injury. Responsive behaviours had been identified for the resident when they injured the other resident. As per the home's Responsive Behaviour Procedure policy, the registered staff was required to complete an Responsive Behaviour Huddle for every physical responsive behaviour.

The ED confirmed that an Responsive Behaviour Huddle was a requirement following a physical responsive behaviour incident.

Upon review of the resident's chart, it was determined the Responsive Behaviour Huddle assessments had not been completed in response to this incident.

A registered staff member stated that an Responsive Behaviour Huddle should have been completed for this incident and the DOC confirmed it was not completed.

Sources: review of the residents' clinical records in PCC, Responsive Behaviour Procedure Policy (CARE3.010.02, last reviewed March 31,2021); interviews with staff, the DOC and the ED.

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