Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 7, 2014	2014_248214_0008	H-000146-14;H-000147-14	Critical Incident System

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

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): February 19, 20, 2014

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care(DOC), Associate Director of Care(ADOC), Resident Services Manager, Staff Educator, Resident Assessment Instrument(RAI) Coordinator.

During the course of the inspection, the inspector(s) interviewed staff and residents, reviewed clinical records, relevant policies and procedures, staff training and education records.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident was protected from abuse.

a) According to the clinical record, on an identified date in January 2014, resident #001, with identified responsive behaviours, was observed to have demonstrated inappropriate behaviour toward resident #002. Resident #001 was observed later the

same day to have made inappropriate comments to residents #002, #003, #004 and #005. Nursing staff informed resident #001, that their comments may cause others to feel uncomfortable.

b) According to the clinical record on an identified date in January 2014, resident #001 was observed to have made inappropriate comments to resident #002 and then observed to have demonstrated inappropriate behaviour toward this resident. Nursing staff documented in the progress notes, strategies to keep the resident busy and prevent engagement with resident #002. Resident #001 was observed later the same day to be involved in "several episodes" of approaching residents #002, #003, #004 and #005 and making inappropriate comments. Nursing staff informed resident #001 to refrain from making the inappropriate comments. Resident #001 was identified later the same day, to have wandered into resident #005's room. Resident #005 who was in bed yelled out, and staff responded. Nursing staff informed resident #001 of the concern of entering into co-residents space and inappropriate conversations. Later this same day, direct care staff observed resident #001's walker outside the room of resident #003 and upon entering the room, observed resident #001 to have inappropriate behaviour toward resident #003. Nursing staff escorted resident #001 from the room and documented in the progress notes that they discussed the inappropriateness of their behaviour.

c) According to the clinical record on an identified date in January 2014, resident #001 was observed to have made inappropriate comments to resident #003. Resident #001 was then observed a short time later, to have demontrated inappropriate behaviour toward resident #002. Nursing staff redirected resident #001. Later this same day, resident #001 wandered into resident #004's room and was observed making inappropriate comments to this resident. Resident #004 indicated to staff to remove the resident. Later this same day, direct care staff observed resident #001 to be demonstrating inappropriate behaviour to resident #003. Staff redirected resident #001.

d) According to the clinical record on an identified date in January 2014, resident #001 was found in resident #005's room, making inappropriate comments. Nursing staff removed resident #001 from the co-residents room and indicated in the progress notes, that resident #001 was, making inappropriate comments.

It was identified through a review of the clinical record, that resident #001 had demonstrated 12 episodes of abuse over four identified dates in January 2014. The

licensee did not protect every resident from abuse. [s. 3. (1) 2.]

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 every resident is protected from abuse, to be implemented voluntarily.

WN #2: 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. (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 did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Resident #006 had a Falls Risk Assessment Tool completed on an identiifed date in December 2013. The assessment allowed for the use of clinical judgement to be applied to issue an automatic high risk fall status, in which interventions of a physiotherapy assessment and identification of a high risk for falls through the use of a falling star logo, would be completed. Registered staff had determined on the assessment that resident was a high risk for falls, however, did not change the risk score on the assessment to "high". As a result, the resident's written plan of care categorized them at a medium risk for falls and a physiotherapy assessment and application of a falling star logo was not implemented. The RAI Coordinator and ADOC confirmed that the assessment was not fully completed and not consistent with the needs of the resident. [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 staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated are consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

The home's policy, Resident Non-Abuse-Ontario (LP-C-20-ON) indicated that any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident, must immediately report that suspicion and the information on which it is based to the Executive Director(ED) of the Home or, if unavailable, to the most senior supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the Home's reporting requirements to ensure that the information is provided to the ED immediately.

Resident #001 was observed and documented by staff to have been involved in 12 incidents of abuse towards co-residents over four identified dates in January 2014. The home's staff did not immediately report any of these incidents on the identified dates in 2014, to the Executive Director or the most senior supervisor, as required by the home's policy. This information was verified by the Executive Director and Director of Care. [s. 20. (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 to ensure that the written policy to promote zero tolerance of abuse and neglect of a resident, is complied with, to be implemented voluntarily.

WN #4: 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 did not ensure that a person who has reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 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.

According to the clinical record, resident #001, with identified responsive behaviours, was identified to have been involved in 12 incidents of abuse toward co-residents on four identified dates in January 2014. The Critical Incident System was not completed by the home until six days following the first incident. The ED confirmed that the home did not immediately report these incidents of abuse to the Director, as required. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the care plan identified any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

a) According to the Community Care Access Centre(CCAC), Behavioural Assessment Form Placement Services, completed on an identified date in January 2014, resident #001 was identified to have inappropriate responsive behaviours. Interventions identified on this form were to tell the resident to stop or separate the resident's. A review of the home's, Resident Admission Assessment/Plan of Care for this resident, identified this behaviour and the potential triggers, however did not identify the safety measures to tell the resident to stop or to separate the resident's, in order to mitigate the risks.

b) According to the Community Care Access Centre(CCAC), Behavioural Assessment Form Placement Services, completed on an identified date in January 2014, resident #001 was identified to have responsive behaviours of agitation as they did not like to be alone. Interventions identified on this form were to provide extra reassurances. A review of the home's, Resident Admission Assessment/Plan of Care for this resident, identified this behaviour and the potential triggers, however did not identify safety measures to provide extra reassurances, in order to mitigate the risks.

An interview conducted with the DOC, confirmed that the Resident Admission Assessment/Plan of Care was the only care plan in place and did not include any safety measures, to mitigate the risks. [s. 24. (2) 2.]

Issued on this 7th day of March, 2014

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