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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 28, 2017	2017_640601_0008	017495-16, 033373-16, 002870-17, 004698-17	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

Long-Term Care Home/Foyer de soins de longue durée

BURNBRAE GARDENS LONG TERM CARE RESIDENCE
320 BURNBRAE ROAD EAST P.O. BOX 1090 CAMPBELLFORD ON K0L 1L0

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

KARYN WOOD (601)

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): April 10, 11, 12 and 13, 2017.

Critical incident Report (CIR) log #017495-16, log #033373-16, log #002870-17 related to allegations of staff to resident abuse.

Critical incident Report (CIR) log #004698-17 related to allegations of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI-Coordinator, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW) and Residents.

Also during the course of the inspection, the inspector toured the home, observed staff to resident interactions, resident to resident interactions, reviewed residents clinical health records and the licensee's investigation documentation.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	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:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as specified in the plan related to responsive behaviours.

Log #002870-17 relating to resident #002:

On an identified date, the RAI Coordinator submitted to the Ministry of Health and Long Term Care (MOHLTC) a Critical Incident Report (CIR) related to an alleged staff to resident physical, verbal and emotional abuse that occurred on an identified date and time.

The CIR indicated that on the identified date and time, PSW #110 observed resident #002 demonstrating responsive behaviours. At this time, PSW #110 observed PSW #109 being rough with resident #002. According to PSW #110, resident #002 grabbed onto the railing and PSW #109 continued to be rough with the resident. The CIR indicated that PSW #110 heard PSW #109 ask resident #002, "What don't you get? Stop going in there". The CIR indicated that PSW #110 intervened and assisted resident #002 away from the situation and the resident settled. PSW #110 indicated that resident #002 was heard saying, “Please don’t be mean”.

Inspector #601 reviewed resident #002’s written plan of care related to responsive behaviours that were in place at the time of incident. It was identified that resident #002 had responsive behaviours and that the resident could become agitated due to loud voices.

Inspector #601 reviewed the documented interventions in place at the time of the incident related to responsive behaviour for resident #002. Resident #002's interventions included to allow the resident time to express feelings and concerns; approach the resident from the front using a calm tone of voice; distract the resident with conversation and determine if the resident needs to use the bathroom.

The care set out in the plan of care for resident #002 was not provided to the resident as specified in the plan related to the management of responsive behaviours when approached by PSW #109 for redirection on the identified date. [s. 6. (7)]

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 care set out in the plan of care for resident #002 is provided to the resident as specified in the plan related to responsive behaviours, to be implemented voluntarily.

WN #2: 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 has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident did not immediately report the suspicion and the information upon which it was based to the Director.

Log #017495-16 relating to resident #001:

Inspector #601 reviewed a Critical Incident Report (CIR) that was submitted to the Ministry of Health and Long-Term Care (MOHLTC).

The CIR indicated that PSW #103 brought forward a concern to the Administrator that resident #001 had reported to PSW #103 that RN #102 had called the resident a name and removed belongings from the resident's drawer. According to the CIR, resident #001 had no ill effect of the incident and denied being treated disrespectfully by RN #102.

During an interview on April 11, 2017 at approximately 0930 hour, the Administrator indicated to Inspector #601 that on an identified date, PSW #103 made him/her aware of the incident involving resident #001 and RN #102. During the same interview, the Administrator indicated that upon becoming aware of the incident an immediate internal investigation was completed. The Administrator indicated that the MOHLTC should have been immediately notified.

The Director was notified approximately one year and seven months following the incident. [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 to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident immediately report the suspicion and the information upon which it was based to the Director, 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 has failed to ensure that the licensee's written policy that promotes zero tolerance of abuse and neglect of residents was complied with for resident #002.

Log #002870-17 relating to resident #002:

A review of the licensee's Zero Tolerance of Abuse and Neglect of Residents policy number AM-6.9 dated June 2015 was completed by Inspector #601.

The policy indicated under procedure:
1. Any person who has reasonable grounds to suspect that a resident has been neglected or abused is obligated by law to immediately report the suspicion and the information upon which the suspicion is based to the Director, Home's Administrator or manager on call.
2. Each incident of neglect or abuse shall be considered and immediately reported as a critical incident and, as such, shall be reported to the Director of Operations and the Ministry of Health and Long Term Care by telephone and computerized submission of a Mandatory Critical Incident System (MCIS) form.
3. In the event of an allegation or complaint of abuse or neglect of a resident the charge nurse in consultation with the manager on call shall assess the risk and severity of the incident and determine the need to relieve the accused person(s) of their duties pending investigation.

The policy indicated under responsibility that:
1. It is the responsibility of every OMNI staff member to report any suspected or witnessed neglect or abuse of a resident as indicated in this policy.
2. It is the responsibility of the Registered Staff to initiate the Mandatory Report Checklist

upon learning of an alleged, suspected or actual incident.

Inspector #601 reviewed a Critical Incident Report (CIR) that was submitted to the Ministry of Health and Long-Term Care (MOHLTCH).

The CIR indicated that on the identified date and time, PSW #110 observed resident #002 demonstrating responsive behaviours. At this time, PSW #110 observed PSW #109 being rough with resident #002. According to PSW #110, resident #002 grabbed onto the railing and PSW #109 continued to be rough with the resident. The CIR indicated that PSW #110 heard PSW #109 ask resident #002, "What don't you get? Stop going in there". The CIR indicated that PSW #110 intervened and assisted resident #002 away from the situation and the resident settled. PSW #110 indicated that resident #002 was heard saying, "Please don't be mean".

According to the same CIR, PSW #110 immediately reported to RN #112 that he/she felt PSW #109 had been "gruff" with resident #002. RN #112 requested that PSW #110 fill out a witness report and later determined that the incident potentially had a verbal, emotional and physical component. RN #112 gave PSW #110's witness report to the Director of Care (DOC) two days after the incident occurred.

During an interview by telephone on April 13, 2017 at approximately 0630 hour, RN #112 indicated to Inspector #601 that on the identified date and time PSW #110 had reported that he/she was upset that PSW #109 had been harsh and inappropriate with resident #002.

During the same interview, RN #112 indicated that he/she did not immediately report the suspicion and the information upon which the suspicion was based to the Director, Home's Administrator or manager on call. RN #112 indicated that upon becoming aware of the allegations, PSW #110 was given a witness report to complete, the Mandatory Report Checklist was not initiated, an immediate investigation was not completed, the resident was assessed as calm and no further action was taken following the allegations of abuse towards resident #002. RN #112 also indicated that the risk and severity of the incident was not discussed with a manager at the time of the incident. RN #112 indicated that PSW #109 worked the remainder of his/her scheduled shift following the allegations of abuse. During the same interview, RN #112 indicated that he/she should have immediately reported the allegations to the manager on call and followed the licensee's Zero Tolerance of Abuse and Neglect of Residents policy.

The Director was notified two days after the incident occurred. [s. 20. (1)]

Issued on this 5th day of May, 2017

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

Original report signed by the inspector.