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
Nov 9, 2014	2014_266527_0020	H-001253-14	Resident Quality Inspection

Licensee/Titulaire de permis

1245556 ONTARIO INC.
200 Ronson Drive, Suite 305, TORONTO, ON, M9W-5Z9

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

BURTON MANOR
5 Sterritt Drive, BRAMPTON, ON, L6Y-5P3

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

KATHLEEN MILLAR (527), IRENE PASEL (510), KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 29, 30 and October 1, 2, 3, 7, 8, 9 and 10, 2014

The Resident Quality Inspection (RQI) included inspections related to the following Critical Incidents: H-000400-14; H-000670-14; H-000732-14; H-000837-14 and H-001110-14

During the course of the inspection, the inspector(s) spoke with residents, family members and Power of Attorney, the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP), the Life Enrichment Manager, the Environmental Services Manager, the Food and Nutrition Manager, Residents' Council President, Vice President and Secretary Treasurer and the President of the Family Council.

During the course of the inspection, the inspector(s) observed all care areas, reviewed the residents clinical records, reviewed the home's policies and procedures, complaints and critical incident logs, training records, employee files, staff schedules and minutes of various committees.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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. 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #100 was assessed in December 2013 as being severely cognitively impaired, and identified the resident was totally dependent on staff to assist using a mechanical lift for all transfers. The assessment also identified the resident was high risk for falls. The clinical record review identified the resident had a history of falls and was known to try and self transfer to the toilet. In January 2014 the resident was transferred to the bathroom by the Personal Care Provider (PCP). The PCP left the resident unattended in the bathroom. When the PCP returned to the resident's bathroom, the resident had fallen and sustained a fracture. The care plan, which the PCPs and registered staff use to direct resident care, identified the resident was totally dependent for all transfers using a mechanical lift and two staff. One staff to operate the lift while the other staff provides support, guides and ensures the resident's safety during the transfer. The care plan also identified that for toilet use, the resident was to be checked and changed in bed for incontinence and was unable to be transferred unto the toilet seat. The PCPs, registered staff and DOC confirmed the resident did not receive the care as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that the plan of care was revised when, the resident’s care needs changed.

A review of the plan of care for resident #300 showed that in April 2014 registered nursing staff identified in the progress notes that resident #300 ate his food fast causing the resident to cough and the diet was changed from regular texture to minced texture. In an assessment completed by the registered dietitian (RD) in April 2014 it was identified that the resident had chewing difficulty and the plan was to continue the minced texture diet the resident was tolerating. In August 2014 it was documented in the plan of care that resident #300 had a choking incident in the dining room. In an interview with staff it was verified that they refer to the care plan for direction on how to provide direct care to residents. A review of the care plan from April to August 2014 did not identify that resident #300 had chewing problems. The current care plan identified a focus related to oral problems with chewing. It further identifies the resident eats food very fast and not chewing properly with specific goals and interventions, which was added to the care plan in August 2014. In an interview with registered nursing staff in October 2014 it was confirmed that resident #300’s care plan was revised to include chewing problems but that is was not done when the resident’s care needs changed during a time period in April 2014. [s. 6. (10) (b)]

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 is provided to residents as specified in the plan, and revised when, the resident's care needs change., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

Residents #203 and #209 shared a room on one of the home areas. The critical incident report identified that in September 2014 while a PCP was providing care for resident #209, resident #203 opened the privacy curtain. Resident #209 was upset and verbalized obscene words directed to resident #203. Resident #203 hit resident #209 in the face. The DOC confirmed that resident #209 was hit in the face by resident #203. [s. 19. (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 residents were protected from abuse by anyone., 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 written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Policy #02-06 titled "Critical Incidents/Mandatory Reports" directs staff that suspected, alleged or witnessed misuse or misappropriation of resident's money must be reported immediately to the Ontario Ministry of Health and Long Term Care (MOHLTC) using a Critical Incident Form. In June 2014 during a care conference, the family of resident #201 disclosed a concern that a staff member had requested that resident #201 purchase gifts for their family at Christmas. A gift list with the staff members name and address was obtained by the family from resident #201. The DOC contacted the family and began an investigation into the allegation in June 2014. The suspected misuse of resident funds was reported to the MOHLTC later in June 2014. The DOC confirmed the report to the MOHLTC was not submitted until later in June 2014. Suspected misuse of resident's money was not reported to the MOHLTC immediately. [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 residents is complied with., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented to ensure that, there was a process to report and locate residents' lost clothing and personal items.

A) In an interview with resident #026 they reported that personal items went missing in August 2014. The resident reported it to staff and the items were not found. A review of the progress notes verified that personal items went missing in August 2014.

B) In an interview with resident #024 they reported that personal clothing went missing in July 2014. The resident reported it to staff and the clothing was not found. During an interview with the PCP in October 2014 they confirmed resident #024 had missing clothing that was not found.

A review of the "Environmental Services" polices and procedures for lost clothing page 11, effective date April 2010 directed staff to complete the form for reporting lost clothing forms found at each nursing station in the request for service book. In an interview with lead of the environmental department in October 2014 it was identified that staff did not fill out the lost clothing report and that no lost clothing reports had been submitted greater than one year. In addition, the policy explained "If after one (1) week the item is not found, arrangements must be made with the resident and/or family member to replace the item at the cost of the facility". In an interview with the lead of the environmental department it was identified that the home did not replace items at the cost of the facility. In an interview with the DOC it was confirmed that the home had not implemented their lost clothing procedures. [s. 89. (1) (a) (iv)]

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 procedures are implemented to ensure there is a process to report and locate residents' lost clothing and personal items., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (5) If a PASD is used under subsection (3), the licensee shall ensure that the PASD is used in accordance with any requirements provided for in the regulations. 2007, c. 8, s. 33. (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Personal Assistance Services Device (PASD) described in subsection (1) that is used to assist a resident with a routine activity of living was included in the residents' plan of care.

Resident #025 was observed in September and several days in October 2014 in a tilt wheelchair. The resident was observed re-positioning in the wheelchair and pulling and fidgeting with their seat belt. The degree of tilt was observed being altered to support the resident's involvement with activities of daily living, such as eating. The PCPs confirmed the tilt wheelchair was used for comfort and positioning, and they adjust the degree of tilt to support the resident's involvement with activities of daily living. The registered staff and ADOC confirmed the resident uses a PASD and it was not included in the resident's plan of care. [s. 33. (3)]

2. The licensee failed to ensure that the PASD used was in accordance with any requirements provided for in the regulations.

Resident #002 was identified as a moderate risk for falls based on the most recent assessment in September 2014. In the resident's plan of care it identifies that they used bed rails for safety and routine activities of daily living. The home had not identified that the resident was using a PASD in the plan of care, and it was not in accordance with the requirements provided for in the regulations. The RPN, the Restorative Care Nurse and the DOC confirmed the resident was using a PASD and the home was not in compliance with the regulations. [s. 33. (5)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed by the method of his or her choice.

In an interview in October 2014 with resident #015 they identified they would like to have both showers and tub baths, but have only received showers. Resident #015 explained they did not know it was an option to have a tub bath and had not been offered a choice related to bathing. A review of the bathing care plan for resident #015 showed the resident liked a shower for one of the scheduled bath days and liked a whirlpool tub bath for the other scheduled bath. A review of the paper bath schedule showed that resident #015 was scheduled for two showers per week. In an interview with the registered and PCPs in October 2014 it was confirmed that resident #015 had not received a whirlpool tub bath. In an interview with two PCPs from resident #015's unit they confirmed they do not offer residents' bathing choice on their bath days. The process was to follow the direction provided on the bath schedule. [s. 33. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that all members of the Residents' Council were residents of the long-term care home.

When reviewing the minutes of the Residents' Council, it was identified that a family member attended the monthly meetings. The Residents' Council President, Vice President and Secretary Treasurer confirmed the family member of resident #110 sits as a member of the Residents' Council. The council members were not aware the membership should only be residents of the home. Interviewed the family member of resident #110 and they confirmed that they were a member of the Residents' Council. The Administrator and the Residents' Council assistant also confirmed that the family member of resident #110 was a member of Residents' Council. The home did not ensure that all members of the Residents' Council were residents of the home. [s. 56. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that concerns or recommendations where responded to in writing within 10 days of receiving Residents' Council advice.

The Resident's Council advised the home of concerns at each of their meetings in January, April, May and June 2014. The concerns and recommendations were not responded to in writing within ten days of the home being advised. The President, the Vice President and the Secretary Treasurer of the Residents' Council confirmed they did not receive the written responses to the residents concerns or recommendations until their meeting the following month. The home's Residents' Council assistant and the Administrator confirmed the written responses were provided to the Resident's Council at the next monthly meeting, and not in writing within 10 days of receiving them. [s. 57. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that consultation regularly with the Residents' Council, has occurred at least every three months.

The President, the Vice President and the Secretary Treasurer of the Residents' were not aware of the home's responsibility to consult with them at least every three months and confirmed that this does not occur.The documentation from the home, and a review of the Residents' Council minutes from 2013 and 2014 did not reflect regular consultation by the home with the Residents' Council. The Residents' Council Assistant was not aware of the licensee requirement, and the Administrator confirmed that regular consultation with the Residents' Council, at least every three months does not occur. [s. 67.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,
(a) is well maintained; O. Reg. 79/10, s. 111. (2).
(b) is applied by staff in accordance with any manufacturer's instructions; and O. Reg. 79/10, s. 111 (2).
(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Personal Assisted Services Device (PASD) used under section 33 of the Act was applied by staff in accordance with the manufacturer's instructions.

In September and October 2014 resident #025 was observed wearing a seat belt (PASD) that was loose. According to the manufacturer's instructions the staff should be able to insert only two fingers between the belt and the resident. In October 2014 over a period of four days the Long Term Care (LTC) Inspector was able to insert a hand between the belt and the resident. The resident's daily visitor also stated the seat belt was always too loose and the resident slides when positioned upright in the chair for lunch. The PCPs and registered staff confirmed the seat belt was loose and not applied according to the manufacturer's instructions. [s. 111. (2) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 228.
Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council.

The Vice President and the Secretary Treasurer of the Residents' Council were not aware of the home communicating improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents. The President identified that this information does not come to the Residents' Council and instead was discussed at another internal committee of the home. In reviewing the home's documentation and the 2013 and 2014 minutes of the Residents' Council, there was inconsistent communication of improvements made through the quality improvement and utilization review system to accommodations, care, services, program, and goods provided to the residents. The Administrator confirmed that there was inconsistencies in the communications and the information was communicated to another committee of the home. [s. 228. 3.]

Issued on this 16th day of November, 2014

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