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
Oct 4, 2016	2016_449619_0029	027800-16	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

SAMANTHA DIPIERO (619), DARIA TRZOS (561)

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 14, 15, 19, 20, 21, 2016.

The following Follow Up inspection was completed:
#004305-16 - related to the minimizing of restraints

The following complaint inspections were complete:
#004305-16 - related to nutrition and hydration, and resident's rights
#027485-16 - related to skin and wound care

The following critical incident inspection was completed:
#017197-16 - related to falls prevention

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Physiotherapist (PT), Life Enrichment Coordinator (LEC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Family Council President, Residents' Council President, residents, and family members. The Inspectors also toured the facility, reviewed the home's policies and procedures, and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 30. (1)	CO #001	2016_210169_0001	561

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. (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).

Findings/Faits saillants :

The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Resident #024 had a plan of care indicating they were at high risk for falls and had a number of interventions in place to prevent falls. PSW #118 and registered staff #121, and #122 that provided direct care to the resident stated that one of the interventions in place was to have the bed in the lowest position while the resident was in bed. Resident's health care records were reviewed and the bed in the lowest position was not documented in the plan of care. Interview with registered staff #122 indicated that when the resident's condition had deteriorated the intervention of placing continence equipment at the resident's bedside was implemented. The registered staff confirmed that this was implemented but could not recall the exact dates. Health care records did not have this strategy documented as to when it was implemented. The ADOC confirmed that the resident did have the continence equipment beside their bed at one point but confirmed that it was not documented in the plan of care. The ADOC confirmed that all planned care in place for prevention of falls were to be documented in the written plan of care.

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 with s. 6. (5) where the licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the Restraints Policy was not complied with.

The home's policy called "Restraints - Physical/Mechanical", policy number 08-18, revised February 2016, indicated "there are not to be any PRN orders for physical restraints. Physician/RN(EC) Order must specify the type of restraint, situations or reasons for its use and how long it can be applied for. The Plan of Care must include the type, frequency of use, reason for use, monitoring by whom and how often, when it is to be released and/or removed, the frequency of repositioning of the resident and post restraint care and safety measures". Resident #025 was observed to be seated in a mobility device on an identified date in September 2016. The plan of care directed staff to position resident in an identified way in the mobility device which would restrain the resident. Interview with the PSW #109 who provided direct care to the resident indicated that the mobility device was considered a restraint and resident was tilted at all times when up in mobility device. After lunch resident was usually released from it and put back to bed until supper and was also released from restraint during meal times. The staff were to monitor resident every hour and reposition every two hours. The ADOC indicated that as needed order was written because the resident was not restrained during meals or when they were in bed. The ADOC confirmed that the plan of care stated that the frequency for the use of restraint was as needed. The licensee failed to ensure that the Restraint policy was complied with.

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 with s. 29. (1) where every licensee of a long-term care home, (a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and (b) shall ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate interventions to promote healing, and prevent infection.

Resident #003 had a fall on an identified date in July 2016, was sent to the hospital to receive medical intervention for an injury. The health care records were reviewed and

indicated that the order for the discontinuation of the medical intervention was not obtained from the physician upon return from the hospital. The weekly skin assessments for the injury were never completed but should have been as confirmed by the registered staff #107 and the DOC. Resident was observed on an identified date in September 2016, and the medical intervention was still in place. The interview with the DOC indicated that the order for the discontinuation of the medical intervention was never obtained on re-admission and therefore never discontinued. The progress notes from an identified date in September 2016, indicated that the order was obtained from the physician on an identified date in September 2016, and the medical intervention was discontinued. The licensee failed to ensure that the resident exhibiting altered skin integrity received interventions to promote healing and prevent infection.

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home.

Resident #003 had a fall on an identified date in July 2016, was sent to the hospital and returned for treatment for an injury obtained as a result of the fall. The health records were reviewed and indicated that the resident was not referred to the Registered Dietitian after the injury. The resident had another fall on an identified date in August 2016, and re-injured the resident in the same area. The Registered Dietitian was interviewed and indicated that they had not received a referral for this resident after the injuries. The interview with the DOC and Administrator confirmed that the referral to the Registered Dietitian should be made for any altered skin integrity issues including skin tears or lacerations.

3. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

Resident #003 had a fall on an identified date in July 2016, was sent to the hospital for treatment for an injury obtained as a result of the fall. Interview with registered staff #107 indicated that the resident's injury was not assessed on a weekly basis, and indicated that staff charted in the progress notes about the resident's injury but did not use a clinically appropriate assessment tool. The health care records were reviewed and the weekly skin assessments using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment were not completed. The DOC confirmed that the weekly skin assessments were not completed and indicated that it

was an expectation that the staff assess residents weekly when there is an alteration in the skin integrity.

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 with r. 50. (2) where every licensee of a long-term care home shall ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: 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 failed to ensure that 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.

The Residents' Council operating within the home submitted complaints/concerns to the licensee in written form after identifying areas of improvement during council meetings. The council’s appointed secretary was identified as the Life Enrichment Coordinator (LEC), and was identified as the person responsible for submitting the complaints/concerns form to the appropriate licensee staff member, and receiving the response from said staff member and providing these responses to the council. In an interview with the Residents' Council representative, it was indicated that the home had on two occasions failed to respond within 10 business days, but was unable to provide specific dates as the council’s response forms were undated. A review of the Residents' Council meeting minutes indicated that complaints/concerns were submitted to the home during the months of January, February, April, August, and September in the 2016 calendar year.

A review of the complaints response forms confirmed that the forms did not have submission dates and did not have response dates included. In an interview with the LEC it was confirmed that they were aware of the licensee’s duty to respond in writing within 10 business days of a complaint/concern being submitted to the home, and confirmed that the dates of complaint/concern submissions and responses were not recorded. The LEC confirmed that some complaint/concern responses were submitted later than 10 business days to the Residents' Council and was unable to provide proof of dates for any complaint/concerns submissions or responses. The DOC confirmed that the home was unable to show proof that the responses had been submitted to the Residents' Council within 10 business days. [s. 57. (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 with s. 57. (2) where 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, to be implemented voluntarily.

WN #5: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007.

On an identified date in September 2016, inspector observed two mobile lab blood work requisition forms in plain sight. The requisitions were sticking out of the lab requisition book and exposed the personal health information of residents #026 and #027 including their full names, birth dates, and health card numbers. Interview with RN #112 indicated that the binder containing exposed personal health information was left on the nursing station desk after the lab technician finished with it, but that the binder was not secured by the home's staff afterward. An interview with the DOC confirmed that the registered staff were required to keep all personal health information for residents out of sight from the public and that this was not done. The DOC confirmed that the residents' personal health information was not protected.

WN #6: 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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy titled, "Medication Pass", policy number 4.07-1, revised October 2015, indicated that the registered staff were to sign for all medications given to the

resident before moving on to another resident. During the observation of the medication pass on an identified date in September 2016, resident #028 requested to receive a medication that was an as needed (PRN) medication. Registered staff #110 checked the Electronic Medication Administration Record (EMAR) and noticed that it was signed as the medication was given at 1537hours. The registered staff from the previous shift was still at the nursing station and indicated that the PRN medication was administered to the resident at 1140 hours but they had signed the EMAR at 1537 hours. The progress notes were reviewed and indicated that the medication was given to the resident but did not indicate the actual time of administration. The DOC confirmed that the EMAR should have been signed immediately after the medication was administered and that the "Medication Pass" policy was not followed.

B) The home's policy titled, “Narcotics and Controlled Drugs”, policy number 3.08-1, revised Oct 2015, indicated that the shift to shift narcotic count must be completed and signed by one nurse going off and one nurse coming on shift, for two signatures total. The narcotic count sheets on an identified home area were reviewed and indicated that on two different days, the end of shift narcotic count sheets were not signed by two registered staff on identified dates in August 2016, and May 2016. The DOC confirmed that the narcotic count sheets should have been signed by both nurses together at change of shift.

C) Resident #024 had a fall on an identified date in April 2016, and the Fall Risk Assessment completed post fall on an identified date in April 2016, indicated that the resident became a high risk for falls, an increase from moderate risk. A review of the written plan of care, last updated in April 2016, indicated that the resident's high risk for falls was not updated and still indicated that resident was at moderate risk for falls. Interview with registered staff #122 indicated that staff were aware the resident was a high risk for falls and confirmed that this was not reflected in the resident's plan of care. The falls policy, policy number 09-01, revised September 2013, indicated that the care plan is to be completed to identify risk level for falls as well as any interventions related to falls. The ADOC confirmed that the level of risk after the identified date in April 2016, as based on the Fall Risk Assessment completed on an identified date in April 2016, was not documented to reflect the change.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were stored in an area or a medication cart, that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

A) On an identified date in September 2016, during the review of the drug destruction process with the DOC, it was observed that two medications that were part of the government stock were expired;
- Bronchophan Expectorant which had an expiry date of July 2016, and was found in a medication room in an identified home area in a cabinet with other medications that were part of the government stock,
- Isopropyl Rubbing Alcohol 70% had an expiry date of February 2015, and was found where all government medications were kept.
The DOC confirmed they these should have been disposed of when they expired.

B) During inspection of the medication cart on an identified home area on an identified date in September 2016, residents #029 and #018 had prescribed, opened medications stored in the medication cart without the date documented when the medications were initially opened. The RPN #117 confirmed that the medications that are part of the government stock required to have documented dates of when they were opened. The ADOC confirmed that it is an expectation that staff label and enter the dates of when the medications are opened, and confirmed that this is a nursing best practice.

Issued on this 11th day of October, 2016

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

Original report signed by the inspector.