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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 10, 2018	2017_482640_0022	027184-17	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

HEATHER PRESTON (640), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 4, 5, 6, 7, 8, 12 and 13, 2017.

During the course of the inspection, the following Critical Incident inspection was completed;

Log #000626 -17 related to the allegation of abuse, resident to resident

During the course of the inspection, the inspector(s) spoke with Housekeeping aides, Personal Care Providers (PCP), Registered Practical Nurses (RPN), Registered Nurses (RN), Assistant Director of Care - Infection Prevention and Control Lead/Nurse Educator, (ADOC/IPAC), Skin and Wound Champion, Director of Behavioural Support, Food and Nutrition Manager (FNM), Director of Care (DOC), Administrator, families, President of Family Council and the President of Resident's Council. The Inspectors also toured the home, reviewed the home's policies/procedures and processes, reviewed clinical records and observed the provision of care.

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

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **7 VPC(s)**
- **1 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 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

In October 2017, the home's specialized care provider observed and documented on the home's 24 hour nursing report that resident #002 had altered skin integrity.
The home's policy Preventative Skin Care, policy number 03-03 with a revised date of November 2013, directed staff to;
- observe the resident`s skin for any changes and report the changes to the registered staff,
- during the bath, staff was to complete a Bath Day Skin and Oral Assessment form,
-circle any areas on the figures and write beside what was noted,
-write the date in the assessment box and initial,

- check the box that stated, `reported to nurse` and report immediately to the nurse,
- if a problem is ongoing, continue to circle the assessment and,
- if the resident refused their bath or shower, staff was directed to date and initial and document on the form, refused and report the refusal to the nurse immediately.
The first assessment which was completed by registered staff, occurred on an identified date in November 2017, over a month after the area of altered skin integrity was identified.
On an identified date in October 2017, the resident's physician ordered treatment.
During an interview, RN #203 informed the Long Term Care Homes (LTCH) Inspector when a note was added to the home's 24 hour nursing report, the report was to be read at each shift.
RPN #211 and the Director of Care confirmed to the LTCH Inspector the home expected that an assessment of the altered skin integrity, as noted by the specialized care provider, be completed using the home's clinically appropriate assessment instrument immediately following the observation. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (ii) received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

On an identified date in October 2017 the home's specialized care provider observed and documented on the home's 24 hour nursing report that resident #002 had altered skin integrity.
The home's policy Preventative Skin Care, policy number 03-03 with a revised date of November 2013, directed staff to observe the resident`s skin for any changes and report the changes to the registered staff.
The first assessment completed by registered staff occurred on an identified date in November 2017, which noted multiple skin integrity issues. The nursing intervention put in place was to closely monitor.
During a review of the clinical record by the LTCH Inspector, it was noted that the resident's physician ordered treatment on an identified date in October 2017.
On a specified date in November 2017, the written plan of care was updated to include the altered skin integrity and directed staff to provide identified treatment.
During an interview with RPN #211, the home's Skin and Wound Champion and the Director of Care, they confirmed that treatment was expected to occur immediately and did not begin until the physician ordered treatment on an identified date in October 2017. [s. 50. (2) (b) (ii)]

3. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) was assessed at least weekly by a member of the registered nursing staff if clinically indicated.

Resident #011 was identified as having two areas of altered skin integrity on an identified date in October 2017.
Policy Wound Care Record, policy number 03-09 with a revised date of January 2011 directed staff to complete a weekly wound assessment on the Wound Care Record, one form for each wound and document any additional information related to wound care and treatment in the progress notes. The plan of care was to be updated with any changes to the wound or treatment.
The Long Term Care Homes (LTCH) Inspector reviewed the clinical record and found the following;

Resident #011 had a wound assessment completed by a member of the registered nursing staff as follows on several identified dates in October and November 2017. The assessments were not consistent and not all areas of altered skin integrity were assessed as per policy.
During an interview with RPN #211, the home's Skin and Wound Champion, they confirmed that a weekly wound assessment was required to be completed for each individual area of altered skin integrity and staff did not complete as noted.
During an interview with the Director of Care (DOC), they confirmed it was an expectation of the home that a weekly wound assessment be completed for each individual area of altered skin integrity and this had not occurred. [s. 50. (2) (b) (iv)]

4. The licensee failed to ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

Resident #011 was identified as having altered skin integrity on an identified date in October 2017.
The home's policy Preventative Skin Care, Policy Number 03-03 with a revised date of November 2013, directed staff to implement specific interventions to aid in healing.
During an interview of PCP #202, they informed the Long Term Care Homes (LTCH) Inspector they did not implement the specific intervention for resident #011.
During an interview with RPN #205 who concluded the specific intervention was not in place for resident #011.

The LTCH Inspector reviewed the clinical record of resident #011 to include the written plan of care with RPN #205. The specific intervention was not included in the plan of care for resident #011.
During an interview with RPN #211, the home's Skin and Wound Champion, and the Director of Care (DOC), they confirmed it was an expectation that the resident have a specific intervention in place and included in the resident's plan of care for resident #011 who exhibited altered skin integrity and was dependent on staff. [s. 50. (2) (d)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 :

1. Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Ontario Regulation 79/10, s.48, required the licensee to ensure that the interdisciplinary programs including skin and wound care, programs were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system, was (b) complied with.

i) Resident #011 had two areas of altered skin integrity identified on an identified date in October 2017.
Policy Wounds - Stasis Ulcers, Surgical Wounds and other Wounds, policy number 03-08 with a revised date of January 2011, directed staff to assess and document the assessment of the wound, assess for pain, contact the MD for treatment orders, complete the wound care treatment as ordered, weekly reassess the status of the wound, update the resident`s plan of care.

A document was provided to the Long Term Care Homes (LTCH) Inspector by the Director of Care(DOC) that listed the required documentation for alteration in skin integrity.

The document directed staff to complete a Risk Management - Occurrence note in Point Click Care (PCC), complete a head to toe skin assessment and a pain assessment, refer the resident to dietary, enter treatment on weekly wound schedule list and set up a weekly wound assessment on the Treatment Administration Record (TAR). The plan of care was to be updated under a Custom Focus and a sample was provided.

The LTCH Inspector reviewed the clinical record of resident #011 and found that an occurrence note, a head to toe assessment and a pain assessment was not completed when the altered skin integrity was first identified.

The LTCH Inspector interviewed RPN #211, the home's Skin and Wound Champion and the DOC who confirmed it was the expectation of the home that when a new area of altered skin integrity was identified, an occurrence note, head to toe assessment and pain assessment were to be completed at the initial identification of the skin integrity concern. For resident #011, these had not been completed as per the home's policies

ii) Resident #002 had altered skin integrity observed during stage 1 of the Resident Quality Inspection process.
On an identified date in October 2017, a Personal Care Provider (PCP) observed altered skin integrity and documented on the Bath Day Skin/Oral Assessment form. The altered skin integrity was documented again on the form on two occasions in November 2017. Later in November 2017, a PCP documented a worsening of the same area.

Policy Preventative Skin Care, policy number 03-03 with a revised date of November 2013, directed staff to observe the resident`s skin for any changes and report the changes to the registered staff. During the bath, staff was to complete a Bath Day Skin and Oral Assessment form twice weekly. Circle any areas on the figures and write beside what was noted. Write the date in the assessment box and initial. Check the box that stated, `reported to nurse` and report immediately to the nurse. If a problem is ongoing, continue to circle the assessment. If the resident refused their bath or shower, staff was directed to date and initial and document on the form, refused and report the refusal to the nurse immediately.

The Director of Care informed the Long Term Care Homes (LTCH) Inspector that it was expected that the nurse review the Bath Day Skin/Oral Assessments on a daily basis and initial where necessary their acknowledgement and follow-up and assess the areas identified by the PCPs.

The LTCH Inspector reviewed the clinical record of resident #002 and was unable to identify any corresponding interventions, assessments or actions taken related to the altered skin integrity documented by the PCPs.
During interviews of PCPs #200, #201 and #202, they informed the LTCH Inspector that when any skin issues were identified during bath day or at any other time, they inform the nurse and document on the Bath Day Skin/Oral Assessment form. They circle the area and write on the picture what they noted. The form is dated for each bath day and the PCPs confirmed they initial the form when completed whether they find any skin issues or concerns or not.
During an interview with the DOC, they confirmed it was an expectation of the home that the registered staff review the Bath Day Skin/Oral Assessment form, initial where necessary and take action to assess the documented area. The assessment was expected to be documented in the progress notes in the clinical record.
The DOC confirmed that staff did not follow the policy related to the Bath Day Skin/Oral Assessments for resident #002. [s. 8. (1) (a),s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system, is (b) complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Findings/Faits saillants :

1. The licensee failed to ensure that drugs that were to be destroyed and disposed of were stored safely and securely within the home, separate from drugs that were available for administration to a resident, until the destruction and disposal occurred.

During the observation of the medication administration program on December 7, 2017, the Long Term Care Homes (LTCH) Inspector reviewed a medication cart with RPN #207 and conducted a narcotic count of the available narcotic medications.
All narcotic medication cards were attached to a plastic ring. The last card on the ring was a discontinued narcotic, specifically three tablets of Hydromorphone (mg) which had been discontinued November 28, 2017.
During an interview with the Director of Care, they confirmed the discontinued narcotic was to have been immediately stored separately from the drugs that were available for administration to a resident. [s. 136. (2) 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 drugs that were to be destroyed and disposed of were stored safely and securely within the home, separate from drugs that were available for administration to a resident, until the destruction and disposal occurred, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Findings/Faits saillants :

1. The licensee failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76(2) of the Act included, (a) Hand hygiene and (d) use of personal protective equipment.

As a result of a review of training and education related to infection prevention and control, the Long Term Care Homes (LTCH) Inspector reviewed the required training and retraining of staff related to Infection Prevention and Control (IPAC).
During an interview of the home's Infection Prevention and Control (IPAC) Lead, they provided the results of the education provided to staff for the year 2016 for;
i) hand hygiene; the home provided training and retraining for hand hygiene for 91.9 percent (%) of required staff, and;
ii) personal protective equipment (PPE); 99.4% of required staff participated in the required training or retraining.
The IPAC Lead confirmed this did not meet the requirements related to the number of staff who were required to have completed the training. [s. 219. (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 the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76(2) of the Act included, (a) Hand hygiene and (d) use of personal protective equipment, to be implemented voluntarily.

WN #5: 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 :

1. The licensee failed to ensure that (a) drugs were stored in an area or a medication cart that, (iv) that complied with the manufacturer's instructions for storage of the drugs.

During the medication administration observation completed December 7, 2017, the medication cart was reviewed with RPN #207.
In the medication cart the following was identified;
Eye drops for residents # 015 and #016 were found to be expired and still in use. The date opened for both products was November 1, 2017. The expiry date was for four weeks from the date opened, therefore November 28, 2017.
During an interview with RPN #207, they confirmed to the Long Term Care Homes (LTCH) Inspector the eye drops were to have been discarded and replaced on November 28, 2017. [s. 129. (1) (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 (a) drugs are stored in an area or a medication cart that, (iv) that complies with the manufacturer's instructions for storage of the drugs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a registered staff permitted a staff member who was not otherwise permitted to administer a drug or a topical to a resident if; (a) the staff member had been trained by a member of the registered nursing staff in the administration of topicals.

During review of resident #002's plan of care related to skin integrity with Personal Care Provider (PCP) #202, they informed the Long Term Care Homes (LTCH) Inspector that they applied topical treatment to resident #002's altered skin integrity. They asked the nurse to provide the treatment to them as it was kept in the medication cart or the medication room.
During an interview with the Director of Care (DOC), they confirmed that PCPs do not apply topical treatments to residents. Registered staff are the only ones approved to apply topical treatment. The home does not have any processes in place to ensure PCPs have the skill and knowledge for them to do this task.
The DOC confirmed the registered staff was to all topical treatments and not the PCPs. [s.131. (4)]

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 registered staff permitted a staff member who was not otherwise permitted to administer a drug or a topical to a resident if; (a) the staff member had been trained by a member of the registered nursing staff in the administration of topicals, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

1) During observation of RPN #207 and their provision of medication administration, the Long Term Care Homes (LTCH) Inspector observed the failure to perform hand hygiene prior to the initiation of the medication administration, between the administration of medications to residents, after doffing gloves, after completing blood glucose monitoring, prior to providing crushed medication in apple sauce (feeding) and prior and post administration of an injection. The LTCH Inspector interviewed the RPN who confirmed they failed to perform hand hygiene during the required moments of care.
The LTCH Inspector interviewed the ADOC/Infection Prevention and Control (IPAC) Lead who confirmed the RPN failed to perform hand hygiene as required.

2) Upon entrance to the home on December 4, 2017, the home had one home area on outbreak precautions. On December 6, 2017, the IPAC Lead informed the LTCH Inspector that the Medical Director of Health placed the entire home on full outbreak precautions.
On December 7, 2017, the LTCH Inspector observed housekeeper #206 on an identified home area. The LTCH Inspector was later on a different home area and observed housekeeper #206 with their equipment. The LTCH Inspector inquired as to where they were scheduled to work. The housekeeper confirmed they were scheduled for a specific home area but had been visiting a resident on another home area.
The LTCH Inspector interviewed the IPAC Lead who confirmed that staff were to be co-horted to their assigned home area and no movement was to occur between home areas.

3) On December 12, 2017, on Gage Park, the LTCH Inspector observed a specialized care provider providing care to resident #018 while wearing gloves. They completed the service for this resident then went to resident #019's room without practicing hand hygiene and provided care to the second resident.
The LTCH Inspector interviewed the specialized care provider who confirmed they had three different products for hand hygiene on their cart but had not used them between the residents and after the doffing of the gloves.
RN #203 confirmed it was the expectation of the home that hand hygiene be performed after the doffing of gloves and between residents and the provision of care. [s. 229. (4)]

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 all staff participated in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, (b) at least annually, the matters referred to in

subsection (1) for Responsive Behaviours, were evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The Long Term Care Homes (LTCH) Inspector reviewed the annual evaluation of the Responsive Behaviours program. The content of the written record did not include a review of the written approaches, written strategies, resident monitoring and internal reporting protocols and the protocols for the referral of residents to specialized resources where required.
During an interview with the Director of Care, they confirmed the written record of the annual evaluation of the Responsive Behaviour program did not include the evaluation of the written approaches, written strategies, resident monitoring and internal reporting protocols and the protocols for the referral of residents to specialized resources where required. [s. 53. (3) (b)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible.

1)On an identified date in January 2017, resident #021 was observed with a responsive behaviour toward resident #020.
On a second identified date in January 2017, resident #021 was found to be at the bedside of resident #020.
According to the report submitted by the home to the Director, resident #021 demonstrated responsive behaviours toward resident #020 in early 2016.
The Long Term Care Homes (LTCH) Inspector reviewed the home's policy entitled Responsive Behaviours, policy number 02-22 with a revised date of September 2013, which directed staff the following;
Each resident displaying responsive behaviour was to have the behaviour observed and assessed. A resident focused care plan was to be developed and maintained.
Review of resident #021's clinical record revealed a focus on the resident's plan of care related to a specific responsive behaviour which initially was identified in October 2015. The written plan of care did not include any triggers for this resident related to this behaviour.
The LTCH Inspector interviewed RN #216, the Director of Behavioural Support and the Director of Care (DOC) who confirmed that resident #020 was the trigger for resident #021. They confirmed the trigger had not been included in the resident's plan of care and it was expected to be included. [s. 53. (4) (a)]

3. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (c) strategies were developed and implemented to respond to these behaviours, where possible.

On an identified date in January 2017, resident #021 was observed demonstrating a responsive behaviour toward resident #020.
On an identified date in January 2017, resident #021 was found to be at the bedside of resident #020.
According to the report submitted by the home to the Director, resident #021 had a specific responsive behaviour toward resident #020 in early 2016.
On an identified date in May 2016, resident #021 had an assessment conducted by a specialized nurse who identified the resident would benefit from activities. The specialized nurse recommended the home implement some activities.
The written plan of care did not include the noted interventions for this resident as recommended by the specialized nurse. Review of the clinical record by the LTCH Inspector and RN #216, revealed no entries related to the trial or implementation of the recommendations.
Review of resident #021's clinical record revealed a focus on the resident's plan of care related to their specific responsive behaviour which initially was identified in October 2015.
RN #216, the Director of Behaviour Support confirmed the resident's plan of care did not include specific strategies to respond to the specific responsive behaviours. After the assessment by the specialized nurse, the assessment and recommended interventions were not implemented.
RN #216 confirmed the home failed to include strategies and interventions as recommended. [s. 53. (4) (c)]

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;
i) that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible and;
ii) that, for each resident demonstrating responsive behaviours, (c) strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Findings/Faits saillants :

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

During the medication administration observation by the Long Term Care Homes (LTCH) Inspector, the LTCH Inspector observed that resident #009 and #012 did not receive their medication as per preferred/prescribed method.
During an interview with RPN #207, they confirmed the medication should be given as per the plan of care.
The LTCH Inspector interviewed the Director of Care (DOC) who informed the LTCH Inspector it was expected that the resident receive the medication as preferred or prescribed. The DOC confirmed staff was expected to provide care as set out in the plan to include the method of medication administration. [s. 6. (7)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Findings/Faits saillants :

1. The licensee failed to ensure that a report was made to the Director of the results of every investigation undertaken under clause (1) (a) regarding alleged, suspected or witnessed incident of abuse of a resident and every action taken under clause (1) (b) relating to appropriate action taken in response to the incident.

The home submitted a Critical Incident report to the Director regarding the allegation of abuse from resident to resident on an identified date in January 2017.
At the time of the inspection of the Critical Incident, the home had not provided a report of the results of the investigation into the allegation to the Director.
The Long Term Care Homes (LTCH) Inspector conducted an interview with the Administrator. They informed the LTCH Inspector they had not received direction from the Director for any further information and therefore did not submit a report with the results of the home's investigation into the allegation of abuse of a resident by a resident. [s. 23. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Findings/Faits saillants :

1. The licensee failed to ensure that a written record relating to the evaluation of the Skin and Wound Care program under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Long Term Care Homes (LTCH) Inspector reviewed the Annual Program and Departmental Evaluation of the Skin and Wound program dated February 2017 for the calendar year of 2016, and found there was no summary of the changes made to the program and no dates those changes were implemented.
During an interview with the Skin and Wound Champion and the Director of Care (DOC) who confirmed there was no summary of changes made to the program and no dates those changes were implemented. [s. 30. (1) 4.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (3) The quarterly evaluation of the medication management system must include at least,
(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk; O. Reg. 79/10, s. 115 (3).
(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 135 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant to the common law duty referred to in section 36 of the Act; and O. Reg. 79/10, s. 115 (3).
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 115 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the quarterly evaluation of the medication management system included at least, (c) identifying changes to improve the system in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The Long Term Care Homes (LTCH) Inspector reviewed the home's Professional Advisory Committee (PAC) meeting minutes for March, June, August and November 2016, as provided by the Administrator as the home's quarterly review of the medication management system.
The LTCH Inspector was unable to note any identified changes to improve the system in the PAC minutes provided and no documentation regarding whether changes were necessary.
Upon review of the PAC meeting minutes with the Director of Care (DOC), they confirmed the home did not identify any changes to improve the medication management system as required. [s. 115. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The Long Term Care Homes (LTCH) Inspector reviewed the Annual Program and Departmental Evaluation for Medication Management.
The Annual Program and Departmental Evaluation for Medication Management meeting was held in February 2017 to review the previous year's medication management program.
Those in attendance at this evaluation did not include the Medical Director, the pharmacist and the registered dietitian.
The Director of Care confirmed the names included as attendees at the annual evaluation of the medication management system were those in attendance and the Medical Director, the pharmacist and the registered dietitian did not attend. [s. 116. (1)]

2. The licensee failed to ensure the annual evaluation of the medication management system, (a) included a review of the quarterly evaluations in the previous year as referred to in section 115; and (c) identified changes to improve the system in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The Long Term Care Homes (LTCH) Inspector reviewed the Annual Program and Departmental Evaluation for Medication Management.
The Annual Program and Departmental Evaluation for Medication Management meeting was held in February 2017 to review the previous year's medication management program.
The meeting minutes did not include the evaluation of the previous year's quarterly evaluations and did not identify changes to improve the system as required.
During a review of the evaluation with the Director of Care (DOC), they confirmed the evaluation of the medication management system did not review the previous quarterly evaluations and did not identify any changes to improve the system. [s. 116. (3)]

Issued on this 25th day of January, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HEATHER PRESTON (640), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2017_482640_0022
Log No. / No de registre :	027184-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 10, 2018
Licensee / Titulaire de permis :	1245556 Ontario Inc. 200 Ronson Drive, Suite 305, TORONTO, ON, M9W-5Z9
LTC Home / Foyer de SLD :	Burton Manor 5 Sterritt Drive, BRAMPTON, ON, L6Y-5P3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Natasha Murray

To 1245556 Ontario Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall;

a) Develop and implement a plan to ensure that skin and wound care assessments are completed when an area of altered skin integrity is identified.

b) The plan will include, but not be limited to;
i) a process to ensure communication between service providers and registered staff is clear and timely and,
ii)training related to the process and an evaluation of the process to ensure that changes to a resident's status are being communicated and immediate actions taken and,

c) Ensure resident #011 has a clinically appropriate assessments and action taken as a result of the assessment as needed.

Grounds / Motifs :

1. The licensee failed to ensure that a resident who exhibited altered skin integrity received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

On a specific date in October 2017, a specialized care provider observed and documented on the home's 24 hour nursing report that resident #002 had altered skin integrity.
The home's policy Preventative Skin Care, policy number 03-03 with a revised date of November 2013, directed staff to observe the resident for any changes and report the changes to the registered staff.
The first assessment completed by registered staff occurred on a specific date in November 2017, which noted multiple areas of altered skin integrity. The nursing intervention put in place was to closely monitor.
During a review of the clinical record by the LTCH Inspector, it was noted that the resident's physician ordered treatment on a specific date in October 2017.
During an interview with RPN #211 and the Director of Care, they confirmed that treatment was expected to occur immediately and did not begin until the physician ordered the treatment four days after the initial observation of altered skin integrity.

(640)

2. The non-compliance was issued as a Compliance Order (CO) due to a

severity level of actual harm, a scope of isolated and a compliance history in the last three years of "ongoing non-compliance with a VPC or CO" related to immediate skin assessment and weekly skin assessments.

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On a specific date in October 2017, a specialized care provider observed and documented on the home's 24 hour nursing report that resident #002 had multiple areas of altered skin integrity.
The first assessment which was completed by registered staff, occurred on a specific date in November 2017, over one month after the area of altered skin integrity was identified,
On a specific date in October 2017, the resident's physician had ordered treatment.
RPN #211 and the Director of Care confirmed to the LTCH Inspector the home expected that an assessment be completed using the home's clinically appropriate assessment instrument immediately following the observation by the specialized care provider.
(640)

3. The licensee failed to ensure that a resident exhibiting altered skin integrity was assessed at least weekly by a member of the registered nursing staff if clinically indicated.

Resident #011 was identified as having two areas of altered skin integrity on a specific date in October 2017.
The home's policy "Wound Care Record", policy #03-09 and revised January 2011, directed staff to complete a weekly assessment using the record for all areas of concern. The plan of care was to be updated with any changes to the care or treatment.
The Long Term Care Homes (LTCH) Inspector reviewed the clinical record and found several dates where assessments were not completed as per the home's policy.
During an interview with RPN #211 and the Director of Care(DOC), they confirmed it was an expectation of the home that a weekly assessment be

completed for each individual area of concern and this had not occurred. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Heather Preston

Service Area Office /
Bureau régional de services : Hamilton Service Area Office