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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
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500 rue Weber Nord
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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
Aug 21, 2018	2018_728696_0004	006920-18, 007052-18, 008687-18, 017949-18	Critical Incident System

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

ZINNIA SHARMA (696)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 25, 27, 30, 31, and August 1, 2, 2018.

During the course of the inspection, the following Critical Incident (CI) intakes were inspected:
Intake #006920-18 related to resident fall with injury.
Intake #007052-18 related to significant change in resident's health condition.
Intake #008687-18 related to resident fall with injury.
Intake #017949-18 related to resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care, Director of Behavioural Support (DBS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Care Providers (PCPs).

During the course of the inspection the Long Term Care Homes (LTCH) Inspector toured the home, reviewed relevant documents including but not limited to: clinical records, and the home's documentation and policies as related to the inspection, and interviewed staff.

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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. 53. Responsive behaviours

Specifically failed to comply with the following:

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 has failed to ensure that behavioural triggers were identified for the resident demonstrating responsive behaviours.

A Critical Incident (CI) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) by the home, indicating that on a specific date, resident #002 had a fall which led to resident being transferred to the hospital. As per the CI report, resident was at high risk for fall and was exhibiting certain behaviour prior to their fall.

On the same day, post fall assessment and multidisciplinary progress note were completed by registered staff which listed resident's prior history of falls and responsive behaviours as possible contributing factors.

The clinical record for the resident #002 was reviewed and in June 2018, staff had documented that resident was exhibiting new behaviours. Dementia Observation Scale (DOS) was initiated for the resident for one week and indicated that the resident was continuously exhibiting certain responsive behaviours during the period.

There was no documentation in the resident #002's clinical record which identified possible behavioural triggers for the resident's behaviours. Resident's written plan of care dated July 2018, for responsive behaviours was reviewed and there were no behavioural triggers identified in it.

Personal Care Provider (PCP) #110, Registered Practical Nurse (RPN) #103, and Registered Nurse (RN) #104 were interviewed and were unsure what the triggers were

for resident #002's responsive behaviours.

The home’s policy "Responsive Behaviours", policy #02-22, with a revised date of September 2013, directed staff to observe and assess residents that were displaying responsive behaviours using tools such as DOS. After the assessment tool was completed, staff were to analyze the information to identify behavioural triggers for the resident and to update their care plan.

Director of Behavioural Support (DBS) told the Long Term Care Homes (LTCH) Inspector that they were responsible for reviewing and analyzing DOS after it was completed for each resident. They acknowledged that behavioural triggers were not identified for the resident #002’s behaviours. [s. 53. (4) (a)]

2. Home submitted a CI report to the MOHLTC, stating that on an identified date, the resident #003 had a fall which led to resident being transferred to the hospital. A post fall assessment was completed by registered staff which listed resident’s history of falls and responsive behaviours as possible contributing factors to the fall.

Resident #003’s clinical record were reviewed and there was Dementia Observation Scale (DOS) initiated in June 2016, however there was no analysis of the DOS documented. Also, there was no other documentation in resident's clinical record which identified the possible behavioural triggers for resident's identified responsive behaviours. There were no triggers identified on the responsive behaviour plan of care which was reviewed in July 2018.

PCP #105 and RN #106 were interviewed and did not know what the triggers were for resident #003's responsive behaviours.

The home’s policy "Responsive Behaviours", policy #02-22, with a revised date of September 2013, directed staff to observe and assess residents that were displaying responsive behaviours using tools such as DOS. After the assessment tool was completed, staff were to analyze the information to identify behavioural triggers for the resident and to update their care plan.

During an interview with DBS, they stated that they were responsible for reviewing and analyzing DOS after it had been completed and behavioural triggers were to be identified for each resident displaying responsive behaviours. They acknowledged that triggers for resident #003’s behaviours were not identified after the DOS had been completed.

The home failed to ensure that, for resident #002 and #003, who were demonstrating responsive behaviours, that the behavioural triggers for the residents were identified, where possible. [s. 53. (4) (a)]

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. 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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

A Critical Incident (CI) report was submitted to the MOHLTC by home, indicating that on a specific date, staff observed resident #005 with a new skin issue of an unknown cause.

Resident #005's progress notes were reviewed and on an identified date in April 2018, registered staff and physician had documented that there was a new skin issue. There was no documentation in resident #005's clinical record which showed that resident had a skin assessment completed on the same day.

RPN #101 and #102 told the LTCH Inspector that if a new skin issue was identified, staff were expected to do a skin assessment using Head to Toe Skin assessment tool.

The home’s policy titled “Head to Toe Assessment”, number 03-04, and last revised November 2013, directed registered staff to assess and record any alterations in skin integrity of a resident using a Head to Toe Skin assessment.

During an interview with Assistant Director of Care (ADOC), they stated that staff were required to use Head to Toe Skin assessment, which was specifically designed for skin and wound assessment, when any new skin issues were identified. They also acknowledged that Head to Toe Skin assessment was not completed on the specific date, when staff observed change in resident #005’s skin condition.

The home has failed to ensure that resident #005 was assessed by the registered staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when they exhibiting altered skin integrity. [s. 50. (2) (b) (i)]

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

The clinical record for resident #005 indicated that on a specific date in April 2018, head to toe skin assessment was completed by registered staff and it was identified that resident had new skin issues. There was no documentation in the resident's clinical record to indicate that a weekly skin assessment was completed for these skin issues.

RPN #101 was interviewed and stated that after a new skin issue, including a bruise, was identified registered staff were expected to do a weekly skin assessment using “Weekly Wound Care Record” and “Weekly Wound Assessment” until the skin issue had resolved.

The home’s protocol titled “Skin Conditions” directed registered staff to assess all the bruises weekly until resolved and document their assessment on Point Click Care (PCC).

ADOC told the LTCH Inspector that it was their expectation that weekly skin assessment was completed for any skin issues until they had resolved. They acknowledged that weekly assessment was never completed for the skin issue on resident #005.

The home has failed to ensure that skin issue on resident #005 had been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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 and is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

Issued on this 12th day of September, 2018

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

Original report signed by the inspector.

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ZINNIA SHARMA (696)
Inspection No. / No de l'inspection :	2018_728696_0004
Log No. / No de registre :	006920-18, 007052-18, 008687-18, 017949-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 21, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee must be compliant with O.Reg.79/10, s. 53 (4).

Specifically, the licensee shall ensure that behavioural triggers for resident #003 and any another residents demonstrating responsive behaviours are identified and analyzed.

The licensee shall review the home's Responsive Behaviour program and policies with all staff members who provide direct care to residents.

Grounds / Motifs :

1. The licensee has failed to ensure that behavioural triggers were identified for the resident demonstrating responsive behaviours.

A. A Critical Incident (CI) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) by the home, indicating that on a specific date, resident #002 had a fall which led to resident being transferred to the hospital. As per the CI report, resident was at high risk for fall and was exhibiting certain behaviour prior to their fall.

On the same day, post fall assessment and multidisciplinary progress note were completed by registered staff which listed resident's prior history of falls and responsive behaviours as possible contributing factors.

The clinical record for the resident #002 was reviewed and in June 2018, staff had documented that resident was exhibiting new behaviours. Dementia Observation Scale (DOS) was initiated for the resident for one week and indicated that the resident was continuously exhibiting certain responsive behaviours during the period.

There was no documentation in the resident #002's clinical record which identified possible behavioural triggers for the resident's behaviours. Resident's written plan of care dated July 2018, for responsive behaviours was reviewed and there were no behavioural triggers identified in it.

Personal Care Provider (PCP) #110, Registered Practical Nurse (RPN) #103, and Registered Nurse (RN) #104 were interviewed and were unsure what the triggers were for resident #002's responsive behaviours.

The home's policy "Responsive Behaviours", policy #02-22, with a revised date of September 2013, directed staff to observe and assess residents that were displaying responsive behaviours using tools such as DOS. After the assessment tool was completed, staff were to analyze the information to identify behavioural triggers for the resident and to update their care plan.

Director of Behavioural Support (DBS) told the Long Term Care Homes (LTCH) Inspector that they were responsible for reviewing and analyzing DOS after it was completed for each resident. They acknowledged that behavioural triggers were not identified for the resident #002's behaviours.

B. Home submitted a CI report to the MOHLTC, stating that on an identified date, the resident #003 had a fall which led to resident being transferred to the hospital. A post fall assessment was completed by registered staff which listed resident's history of falls and responsive behaviours as possible contributing factors to the fall.

Resident #003's clinical record were reviewed and there was Dementia Observation Scale (DOS) initiated in June 2016, however there was no analysis of the DOS documented. Also, there was no other documentation in resident's clinical record which identified the possible behavioural triggers for resident's identified responsive behaviours. There were no triggers identified on the responsive behaviour plan of care which was reviewed in July 2018.

PCP #105 and RN #106 were interviewed and did not know what the triggers were for resident #003's responsive behaviours.

The home's policy "Responsive Behaviours", policy #02-22, with a revised date of September 2013, directed staff to observe and assess residents that were displaying responsive behaviours using tools such as DOS. After the assessment tool was completed, staff were to analyze the information to identify behavioural triggers for the resident and to update their care plan.

During an interview with DBS, they stated that they were responsible for reviewing and analyzing DOS after it had been completed and behavioural triggers were to be identified for each resident displaying responsive behaviours. They acknowledged that triggers for resident #003's behaviours were not identified after the DOS had been completed.

The home failed to ensure that, for resident #002 and #003, who were demonstrating responsive behaviours, that the behavioural triggers for the residents were identified, where possible.

The severity of this issue was determined to be a level 2 as there was Potential for Actual Harm to the resident. The scope of the issue was a level 3 as it related to two of three residents reviewed. The home had a level 4 history as they had a related non-compliance with this section of the LTCHA that included:

- Voluntary Plan of Correction issued December 4, 2017, (2017_482640_0022). (696)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 19, 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 21st day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Zinnia Sharma

Service Area Office / Bureau régional de services : Central West Service Area Office