Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2020	2019_826606_0028	019032-19, 021655-19	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

JANET GROUX (606)

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): December 10, 11, 13, 16, and 17, 2019.

The following intakes were inspected:
Log #021655-19 regarding a resident fall resulting in a significant change in condition; and Log #019032-19, regarding a resident to resident physical altercation resulting in a significant change in condition.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Acting Assistant Director of Care ((A) ADOC), the Behavioural Support of Ontario (BSO) Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Residents.

The Inspector also toured resident living areas; observed resident-staff interactions; reviewed relevant clinical records, investigation records, meeting minutes, staff training records and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident (CI) reported resident #002 fell during care and sustained a significant change in condition.

Resident #002's clinical records stated the resident was found on the floor by Registered Practical Nurse (RPN) #109. Personal Support Worker (PSW) #110 told the RPN that resident #002 had exhibited responsive behaviours. The PSW said they stopped care and re-approached the resident. While PSW #110 was providing care the second time, resident #002 fell.

Resident #002's plan of care stated the resident required a number of staff for an identified activity of daily living (ADL). RPN #110 confirmed this and said that PSW #109 told them they had provided care to resident #002 by themselves.

The Director of Care (DOC) acknowledged that PSW #109 did not provide the required level of assistance for an identified ADL with resident #002 as specified in the resident's plan of care.

The licensee has failed to ensure that the care set out in the plan of care was provided resident #002 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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,
(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; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

A CI reported resident #002 fell during care and sustained a significant change in condition and was transferred to the hospital.

Resident #002 was readmitted to the home on an identified date with with an area of altered skin integrity.

Resident #002's admission assessments from the hospital were reviewed and there was no evidence that an initial skin assessment was completed for the altered skin integrity.

RPN #110 and the DOC acknowledged that an initial skin assessment for resident #002's altered skin integrity was not completed as required.

The licensee has failed to ensure that resident #002's altered skin integrity was assessed by a member of the registered nursing staff after they returned from hospital.

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 resident exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return from hospital, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm as a result of a resident's behaviours, including responsive behaviours, and that minimized the risk of altercations and potentially harmful interactions between and among residents.

A CI reported a resident to resident altercation which resulted in a serious injury.

Resident #001's clinical records stated resident #003 was observed by staff attempting to engage resident #001 in conversation. When resident #003 would not stop, resident #001 became upset and exhibited responsive behaviours toward resident #003 which caused resident #003 to fall and sustain an injury.

Further review of resident #001 and #003's clinical records identified that an altercation occurred between the two residents two days prior to the above mentioned incident. Resident #001 and #003's clinical records did not show that a follow up was completed to establish what lead to the altercation.

Resident #001's plan of care identified that the resident may display specified responsive behaviours when identified triggers were present and a number of interventions to manage them were outlined.

Resident #003's plan of care identified that the resident was cognitively impaired and could display an identified responsive behaviour. The staff were directed to first determine the causes or reasons behind the behaviour. Resident #003's plan of care did not address the resident's responsive behaviour that may have triggered resident #001 and the altercation with resident #003.

Resident #001 and #003's clinical records and plans of care did not show evidence that either resident was re-assessed and their plans of care revised to prevent recurrence of altercations. There was no evidence that interventions in the plan of care were implemented and there was no evidence of heightened monitoring for either resident.

Personal Support Worker (PSW) #100, Registered Nurse (RN) #106, and the Behavioural of Ontario (BSO) Lead stated that resident #001 had exhibited a specified responsive behaviour in response to an identified trigger. They shared that resident #003 was known to have an identified responsive behaviour and that this behaviour may have triggered resident #001 and the ensuing altercation

The Acting ADOC and the BSO lead stated that when an incident has occurred between residents, the staff were expected to complete a number of assessments, review and update the residents' plans of care and initiate further monitoring to assist staff to manage further incidents. They acknowledged that this was not completed for the identified incident between resident #001 and #003.

The licensee failed to ensure that procedures and interventions were implemented to assist resident #003 who was at risk of harm as a result of resident #001's responsive behaviours, and that minimized the risk of altercations and potentially harmful interactions between resident #001 and #003. [s. 55. (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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm as a result of a resident's behaviours, including responsive behaviours, and that minimized the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 15th day of January, 2020

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

Original report signed by the inspector.