Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
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Original Public Report

Report Issue Date May 19, 2022
Inspection Number 2022_1436_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
1245556 Ontario Inc.

Long-Term Care Home and City
Burton Manor, Brampton

Lead Inspector
Daniela Lupu (758)

Additional Inspector(s)
Janet Groux (606)

Inspector Digital Signature
Daniela Lupu
2022.05.25 16:35:49 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 9-13, and 16, 2022.

The following intake(s) were completed in this Critical Incident System inspection:

- Log #016585-21, Log #017521-21, Log #018705-21, Log #021063-21, and Log #001758-22, were related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC#001 Written Notification pursuant to FTCHA, 2021, s. 154 (1) 1

Non-compliance with: LTCHA, 2007 s. 6 (7)

The licensee has failed to ensure that the plan of care for falls prevention was followed for one resident.

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Rationale and Summary
A resident was at risk for falls due to their medical condition and history of falls. The resident's plan of care directed staff to provide specific strategies to prevent falls.

An incident occurred where a falls-prevention strategy was not provided as outlined in the resident's plan of care. The resident had an injury which resulted in a change in their condition.

The home's Falls Lead and the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) Coordinator said that staff should have provided the needed assistance to the resident as specified in their plan of care.

By not following the plan of care for falls prevention, there was a moderate risk to the resident as the staff could not intervene in a timely manner to assist the resident.

Sources: A critical incident report, a resident's clinical records, and interviews with PSWs, RPN, the home's Falls Lead, DOC and other staff. [758]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary
According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 10.4 (h), indicates that the licensee shall ensure that the hand hygiene program includes policies and procedures, as a component of the overall IPAC program, as well as support for residents to perform hand hygiene prior to receiving meals and snacks.

The home's hand hygiene policy documented that all residents will be encouraged and assisted to perform hand hygiene before and after meals or snacks.

On one occasion, during snack service, a PSW did not encourage or assist 13 residents with hand hygiene before they received their snacks.

On a second occasion, during snack service in a different home area, three PSWs did not encourage nine out of 13 residents with hand hygiene before they received their snacks.

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The home's DOC and the IPAC Lead said hand hygiene should have been offered to the residents prior to receiving their snacks.

Gaps in residents' hand hygiene practices before they received their snacks, increased the risk of possible transmission of infectious microorganisms.

Sources: observations of snack service, the home's hand hygiene policy, IPAC Standard (April 2022), and interviews with a PSW, IPAC Lead and DOC. [758]