Ontario

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

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

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Original Public Report

Report Issue Date: November 9, 2022
Inspection Number: 2022-1436-0002
Inspection Type: Complaint Critical Incident System
Licensee: 1245556 Ontario Inc.
Long Term Care Home and City: Burton Manor, Brampton

Lead Inspector	**Inspector Digital Signature**
Janet Groux (606)	Janet Groux Digitally signed by Janet Groux Date: 2022.11.23 09:04:08 -05'00'

Additional Inspector(s)
Romela Villaspir (653)
Najat Mahmoud (741773)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 3-6, and 11-14, 2022.

The following intake(s) were inspected:

- Intake #00002312-22, intake #00002414-22, and intake #00004852-22 regarding the home's falls prevention and management program.
- Intake #00003439-22, and intake #00006470-22, and regarding residents with injuries of unknown causes.
- Intake #00004931-22 regarding a complaint related to a resident's skin and wound care, and medication management.

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

Infection Prevention and Control
Medication Management

Resident Care and Support Services
Falls Prevention and Management
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC)

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, 2021, s. 102(2)(b)

The licensee has failed to ensure any standard issued by the Director with respect to infection prevention and control was implemented.

Rationale and Summary:
In accordance with the IPAC Standard for LTCHs, dated April 2022, section 9.1 documented that the licensee shall ensure that additional precautions are followed in the IPAC program, including the appropriate selection, application, removal and disposal of Personal Protective Equipment (PPE).

The home's policy titled, "Cleaning and Disinfecting of Resident's Room and Equipment", said that before cleaning a resident's room, staff were to follow the precautions required, clean their hands, and put on the appropriate PPE on entering the room. Upon leaving the room, staff were to clean their hands.

a) A staff on a resident home area (rha) was observed cleaning a resident's room that required additional contact precautions. The staff exited the resident's room and entered another resident's room without removing their gloves and performing hand hygiene.

The staff stated that the expectation was to change gloves after exiting each resident's room to minimize the spread of infectious disease.

b) The home's policy titled "Protective Barriers", stated all staff and health care professionals shall practice measures to prevent or minimize the spread of infection and

depending upon the degree of risk for direct contact with blood or other bodily fluids from the skin and or mucous membranes, PPE such as gloves, gowns, masks/N95 and protective eyewear will be used.

A staff was observed entering a resident's room, that required additional droplet precautions without donning the required PPE. The staff acknowledged that they should have worn gloves, gown and eye protection but did not.

Failure to follow PPE donning/doffing protocols increased the risk of harm to residents from the possible transmission of infectious agents.

Sources: The home's policy on Cleaning, disinfecting, and Sterilization of Medical Equipment, and Protective Barriers, observations of staff, staff interviews and IPAC standards for LTCH's [741773] [606]

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. 93(2)(b)(i)

The licensee failed to ensure that procedures were implemented for cleaning and disinfecting transfer equipment.

Rationale and Summary:
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the IPAC program has measures in place to prevent the transmission of infections.

The home's policy titled, "Cleaning, Disinfection and Sterilization of Medical Equipment", stated hydraulic lift machines must be cleaned and disinfected with a low-level disinfectant. For residents on additional precautions, portable equipment must be disinfected with approved disinfectant before use on another resident.

A staff removed a cart with a mechanical transfer lift on it from a resident's room identified on droplet precautions. The staff took the cart with the mechanical transfer lift to another resident's room, a resident room that was not identified on any precautions. After, the staff returned the cart with the mechanical transfer lift to the spa room for storage and exited the room.

The staff acknowledged they did not disinfect the lift before and after they used the lift on the residents that morning.

Failure to disinfect the ceiling lift prior to using it and between residents may have increased the risk of harm to residents related to the transmission of infectious agents which included COVID-19.

Sources: Observations, the home's policy Cleaning, disinfecting, and Sterilization of Medical Equipment, and staff interviews and IPAC standards for LTCH's. [741773] [606]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA 2021, s. 26(1)(c)

The licensee has failed to ensure that a written complaint related to the care of a resident was forwarded immediately to the Director.

Rationale and Summary:
An email from a resident's Substitute Decision Maker (SDM), outlined their concerns regarding the resident's care.

The resident's SDM expressed concerns in their email regarding how the resident's care was managed leading up to their hospitalization and diagnosis of a medical condition.

The Director of Care (DOC) acknowledged that the complaint letter was not submitted to the Director.

Sources: an email from a resident's SDM, and interview with the DOC. 741773] [606]