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

Central West District
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Original Public Report

Report Issue Date: July 23, 2024

Inspection Number: 2024-1436-0002

Inspection Type:
Critical Incident

Licensee: 1245556 Ontario Inc.

Long Term Care Home and City: Burton Manor, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 11-12, and 15-16, 2024.

The following intake was inspected:

Intake #00112528, related to an incident of alleged abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's plan of care related to responsive behaviours included clear directions to staff who provided direct care to the resident.

Rationale and Summary

A resident had a history of responsive behaviours.

In a four-month period, the resident had identified responsive behaviours on multiple occasions. On one of these occasions, the resident received behaviour support that was noted effective, however it was unknown what interventions were provided.

Two Personal Support Workers (PSWs) said they provided different interventions when the resident had the identified responsive behaviours, but none of these interventions were included in the resident's plan of care.

The Director of Care (DOC) said that interventions to manage the resident's identified

responsive behaviours should have been included in the resident's plan of care.

By not including clear directions in the resident's plan of care related to the identified responsive behaviours, staff were unsure which interventions to provide which often resulted in them having difficulties to provide the resident specific care.

Sources: a resident's clinical records, the home's investigation notes, and interviews with PSWs, a Registered Practical Nurse (RPN) and the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that when staff had reasonable grounds to suspect that abuse of a resident had occurred, they immediately reported the suspicion and the information upon which it was based to the Director. Pursuant to s. 154 (3), the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

Rationale and Summary

An RPN was informed of allegations of abuse of a resident. The RPN said they

reported this incident to their supervisors.

The incident was not reported to the Director until eight days later, when a written complaint related to the same allegations was received by the Executive Director and the DOC.

An Associate Director of Care (ADOC) and the DOC said they were not aware of these allegations when the incident occurred, and that staff should have informed them immediately.

By not reporting allegations of abuse of a resident immediately to the Director, it limited the Director's ability to respond to the incident in a timely manner.

Sources: a critical incident report, a resident's clinical records, the home's investigation notes, and interviews with an RPN, an ADOC and the DOC.