Ontario

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 31, 2013	2013_215308_0003	H-001146-12	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

MELODY GRAY (308)

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): January 24, 25, 28, and 29, 2013.

During the course of the inspection, the inspector(s) spoke with The Director of Care, the physiotherapist, the Nursing Rehabilitation/Restorative Care Manager, Registered Nursing staff, personal support workers and the resident's spouse.

During the course of the inspection, the inspector(s) Reviewed the resident's record, the record of the home's investigation into the incident and the home's abuse policies.
The home was toured and staff members' interactions with residents observed.
The resident was observed.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. In June 2012, resident # 001 was noted to have an injury of unknown origin. The physician and the resident's spouse were notified and the resident was sent to the hospital. Resident 001's plan of care (Nursing Care Plan)in effect at the time, indicates that the resident is dependent with the need for two staff assisting with dressing. However, interview with personal support worker staff and review of home's investigation notes reveal that on the date of the incident, and the mornings prior, only one staff (personal support worker) assisted the resident with dressing the top half the resident's body. [s. 6. (7)]

Ontario

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

Issued on this 31st day of January, 2013

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

M. GRAY