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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Dec 28, 2018	2018_689586_0027	022470-17, 009637-18, 016730-18, 017847-18, 019253-18, 026297-18, 027475-18, 028325-18	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Burloak
5959 New Street BURLINGTON ON L7L 6W5

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

JESSICA PALADINO (586), CATHIE ROBITAILLE (536)

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 12, 13, 14, 17, 18, 19, 20 and 21, 2018.

The following Critical Incident System (CIS) inspections were completed:
016730-18, 019253-18, 027475-18 - Prevention of Abuse and Neglect;
026297-18 - Prevention of Abuse and Neglect;
017847-18 - Prevention of Abuse and Neglect;
022470-17 - Falls Prevention;
009637-18 - Falls Prevention; and,
028325-18 - Falls Prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOC), Recreation Manager, Resident Services Coordinator (RCS), registered nurses (RN), registered practical nurses (RPNs), housekeeping staff, one-to-one staff, personal support workers (PSW), residents and families.

During the course of the inspection, the inspector(s) toured the home, observed resident care and reviewed resident health records, policies and procedures, staff files, meeting minutes and call bell records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was protected from physical abuse.

A) O. Reg. 79/10, s. 2 (1) defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

On an identified date in 2018, resident #001 the resident received an assessment due to responsive behaviours toward resident #002. As a result, a specific intervention was put in place for the resident.

According to the home's internal investigation notes and review of the resident health records, resident #001 demonstrated responsive behaviours toward resident #002.

In an interview with PSW #102, who responded to the incident, they confirmed that resident #002 sustained injury.

Resident #002 was not protected from physical abuse by resident #001.

B) The licensee has failed to ensure that every resident was protected from emotional abuse.

O. Reg. 79/10, s. 2 (1) defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

According to the home's internal investigation notes, on an identified date in 2018, PSW #110 communicated to resident #003 in an inappropriate verbal interaction. This was witnessed by staff #112.

Through interviews with staff #112, #113 and #100, all confirmed the resident's response as a result of the incident.

In an interview with resident #003, they also confirmed the incident and the outcome.

In an interview with registered staff #100 and the ED, they acknowledged that resident #003 was not protected from emotional abuse by PSW #110.

C) The licensee has failed to ensure that residents were not neglected by the licensee or staff.

O. Reg. 79/10, s. 5, defines neglect as, "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

Resident #004 had a diagnosis related to their specified care needs that staff in the home were aware of.

According to the home's internal investigation notes, on an identified date in 2018, resident #008 was left unattended in an identified location for an extended period of time.

On a later date in 2018, resident #008 requested specified care but this was not provided to them.

On a later date in 2018, resident #008 requested specified care and this was not provided to them for an extended period of time.

Through interviews with the Recreation Manager and the ED, they confirmed the above incidences. They acknowledged that there was a pattern of inaction by staff in regard to the specified care of this resident. [s. 19. (1)]

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 every resident is protected from abuse and neglect by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy promote zero tolerance of abuse and neglect of residents was complied with, according to s. 20 (2) (d).

The licensee's policy, 'Resident Non-Abuse Program' indicated that anyone who became aware of or suspected abuse or neglect of a resident must immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on shift.

On an identified date in 2018, staff #113 witnessed an incident between PSW #110 and resident #003.

After the incident, the staff completed their tasks and went to another area of the home when another staff member encouraged them to report what they had witnessed. In an interview with the staff member, they confirmed that they did not immediately report the incident to the ED or their supervisor.

Registered staff #113 and the ED confirmed that the staff #113 should have immediately reported the incident and that the home's policy was not complied with. [s. 20. (1)]

Issued on this 2nd day of January, 2019

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

Original report signed by the inspector.