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 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
Jan 2, 2019	2018_541169_0003	016554-18, 019883-18	Complaint

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

YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 12, 13, 14, 17, 18, 19, 20 and 21, 2018.

The following complaint inspections were completed:
#019883-18 and #016554-18 - related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with personal support workers (PSW), registered practical nurse (RPN), registered nurse (RN), Resident Services Coordinator, Recreation Services Manager, Business Office Manager, Associate Director of Care, Director of Care, Executive Director (ED).

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

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the screening measures shall include criminal reference checks.

In 2018, a critical incident #2857-000017-18 was received by the Ministry of Health and Long Term Care (MOHLTC) that identified improper\Incompetent treatment of a resident that resulted in harm or risk to resident #007. In 2018, a complaint #019883-18 was received by the MOHLTC regarding the same incident.

The critical incident #2857-000017-18 identified the following: PSW #105 was providing care for the resident. PSW #106 arrived to assist with transferring the resident to their wheelchair. PSW #107 arrived to assist PSW #105 with repositioning the resident in their chair. At that point in time, PSW #106 observed an alteration in skin integrity on the resident and reported it to the nurse who implemented a treatment plan.

In 2018, the Executive Director provided the inspector with the requested human resource file of a staff member. A criminal reference check was not available in the requested employee file. The Executive Director confirmed that the staff member did not have a criminal reference check conducted prior to hire.

The licensee failed to ensure the staff member was screened, including a criminal reference check prior to hire. [s. 75. (2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a verbal complaint made to the licensee concerning the care of resident #007 had a response made to the person who made the complaint, indicating what the licensee had done to resolve the complaint.

In 2018, complaint #019883-18 was received by the Ministry of Health and Long Term Care, that identified concerns related to the lack of follow up by the licensee to the complainant.

In 2018, resident #007 sustained an alteration in skin integrity. In 2018, a situational care conference occurred to discuss concerns raised by the complainant. There was an outstanding issue and the licensee agreed to follow up and provide a response to the complainant. This response did not occur to the complainant. This was confirmed by the lack of documentation on the client service record completed by the home and the critical incident report received by the Ministry of Health and Long Term Care. The Recreation Manager who attended the situational conference, confirmed a response was not provided to the complainant.

The licensee failed to ensure that a response was made to the complainant, indicating what the licensee had done to resolve the complaint. [s. 101. (1) 3.]

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.