Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 11, 28, Sep 23, Oct 14, 2011	2011_070141_0010	Mandatory Reporting

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Mandatory Reporting inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, and nursing staff

During the course of the inspection, the inspector(s) Reviewed resident's records, home's investigation notes,and home's policies and procedures for Fall Intervention Risk Management, Transferring Requirements, and Documentation

The following Inspection Protocols were used during this inspection:

Falls Prevention

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following subsections:

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. The care for an identifed resident was not provided as set out in the resident's plan of care. The resident fell in 2011 while being assisted by one Personal Support Worker (PSW) in bathing. The fall resulted in an injury. The resident's plan of care stated three staff should provide some physical assist for bathing as resident refuses to be bathed. s.6(7)

WN #2: 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 subsections:

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. An identified resident was neglected by the staff in the home. The resident had a fall in the presence of the first PSW. The resident was transferred to a chair by 2 PSWs, without assessment by a registered nursing staff. The resident complained of an inability to weight bear and pain when transferred to the chair. The first PSW then proceeded to provide care without the 2nd PSW. The first PSW then left the resident alone for approximately 45 minutes, without access to a call bell, while the PSW completed the nourishment pass for the home area. Staff who found the resident described them as being slouched in the chair and when they attempted to straighten them pain was evident. The fall and subsequent change in mobility status was not reported to the charge nurse at the time of the incident. The resident was transferred to hospital for further assessment. As result of injuries resident's care needs for multiple activities of daily living have increased. s.19(1)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. An identified resident was not transferred by staff in a safe manner. The resident had a fall in 2011 while in presence of a Personal Support Worker (PSW). As a result of the fall the resident was unable to stand and expressed pain. The resident was transferred to their bedroom using the sit/stand lift without transferring the resident to another chair for mobilizing. The resident was not assessed by a registered staff prior to using the sit/stand lift. r.36

Issued on this 28th day of November, 2011

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