Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jul 15, 2020	2020_543561_0006	013106-20	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

DARIA TRZOS (561), EMMY HARTMANN (748)

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): July 2, 3, 6, 7, 8, 9, 13, 2020.

This Complaint inspection with the log #013106-20 was related to a change in condition, falls and an injury of unknown cause.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Interim ED, Interim Associated Director of Care (ADOC), Physiotherapist (PT), registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), personal support workers (PSWs), Substitute Decision Maker (SDM), and the resident.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed clinical records, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

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. 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. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001, as specified in the plan.

A complaint was submitted to the Ministry of Long Term Care (MLTC) related to several resident care concerns including a resident's fall, and a change in their health condition.

During a review of resident #001's progress notes, it was identified that the resident had several falls in 2019. The resident did not sustain any injuries related to their falls, and the substitute decision maker (SDM) and the physician were notified after each incidence of fall.

During a review of resident #001's plan of care, it was identified that the resident was at an identified risk for falls and they had several fall interventions in place.

During an observation of resident #001's room during this inspection, one of the identified interventions were not in place.

An interview with PSW #114 and PSW #111 indicated that when they worked on specified dates, the identified intervention was not in place.
RN #112 was interviewed and indicated that if the resident had the identified intervention in place it would be located in their room. They checked resident #001's room and verified that it was not in place.

During an interview with ADOC #113, they identified that resident #001 should have this intervention in place as a falls prevention strategy and it would be kept in the resident’s room. Inspector #748 and Inspector #561 accompanied ADOC #113 to the resident's room where ADOC #113 confirmed that the identified intervention was not present in the room.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital was reported to the Director.

A complaint was received by the Director indicating that resident #001 sustained an injury of unknown cause.
Clinical record review indicated that on an identified dated in 2019, Physiotherapist (PT) had completed an assessment of the resident as the resident complained of a new condition. A progress note indicated that the physician had assessed the resident and ordered a test. The home received the results of the test which showed an injury. The resident was sent to the hospital for further assessment. The resident returned from the hospital with an intervention.

The plan of care for resident #001, was reviewed and indicated that the resident had a change in transfer and ambulation as a result of this injury. The resident was also

ordered a new medication to treat a change in the condition.

PT was interviewed and stated that they assessed the resident on the identified date as the resident complained of a change in condition. PT confirmed transfer and ambulation status had changed post injury.
Interview with PSW #107, who provided direct care to the resident, indicated that the resident's status related to transfer and ambulation had changed after the resident sustained the injury.

The home has not submitted a Critical Incident System (CIS) report related to this injury of unknown cause that resulted in the significant change of the resident's health condition. O. Reg. 79/10, defines 'significant change' as a major change in the resident's health condition that will not resolve itself without further intervention, impacts on more than one aspect of the resident's health condition, and requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

Interviewed the Interim ED and the current ED in the home and they confirmed that the resident sustained an injury for which they were sent to the hospital and had a significant change in their health condition; however, they did not submit a CIS report as they did not feel there was an incident, as the injury was pathological in nature.

The licensee failed to ensure that an incident that caused an injury to resident #001, that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital was reported to the Director. [s. 107. (3)]

Issued on this 16th day of July, 2020

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

Original report signed by the inspector.