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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 24, 2015	2015_236572_0011	O-000955-14, O-001523-15	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

BURNBRAE GARDENS LONG TERM CARE RESIDENCE
320 BURNBRAE ROAD EAST P.O. BOX 1090 CAMPBELLFORD ON K0L 1L0

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

BARBARA ROBINSON (572)

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): March 30, 31 and April 1, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the RAI Coordinator, family members and residents. The inspector(s) also toured the home, observed residents' care and services, reviewed resident health care records, education records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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	Legendé 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 8(1) whereby the licensee did not ensure that the plan, policy, protocol, procedure, strategy or system related to the skin and wound care program was complied with.

In accordance with O. Reg. 79/10, s.30(1)1. and O. Reg. 79/10 s.48(1)2. the licensee is required to have a skin and wound care program that includes a written description of the program that includes goals, objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.

Re: Log #O-001523-15
The home's policy #CS-13.11, "Care of a Resident Confined to Bed" states "Residents shall be turned every two (2) hours with special skin care to back, skin folds and bony prominences.

A review of the healthcare record and Critical Incident Report #2686-000001-15 for Resident #1 indicated that the Resident had multiple comorbidities. Resident #1 was receiving palliative care in the home and required the assistance of two people for bed mobility.

On a specified date, PSW #S104 and PSW #S105 reported to RN #S110 that Resident #1 was found at 0445 on the third round of the night shift, sleeping on a bedpan which had been in place since the previous evening shift, sometime between 1900 and 2000. His/her call bell was out of reach, wedged between the siderails but his/her personal alarm was clipped in place. Resident #1 was immediately removed from the bedpan and RN #S110 completed pain and skin assessments. The Resident's skin on was marked and reddened.

In an interview on March 31, 2015, PSW #S106 and PSW #S107 both said that the evening of the incident was very busy and that they each thought the other PSW had removed the bedpan from Resident #1.

In an interview on March 31, 2015, PSW #S104 and PSW #S105 said that they were not informed that Resident #1 was on the bedpan at the beginning of the night shift. In addition, they said that they did not reposition Resident #1 every 2 hours and thus discover the bedpan on the first two rounds of the night because the Resident had asked not to be disturbed until the third round on the night shift. They acknowledged that there

was nothing in the written plan of care to support the practice of not repositioning the Resident until the third round on the night shift.

In an interview on April 1, 2015, the DOC confirmed that Resident #1 should have been repositioned every two hours with special skin care as per the home's policy. The four PSWs were disciplined by the home. [s. 8. (1) (a),s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 98 whereby the licensee did not ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense.

Re: Log #O-001523-15
A review of the healthcare record and Critical Incident Report #2686-000001-15 for Resident #1 indicated that the Resident had multiple comorbidities. Resident #1 was receiving palliative care in the home and required the assistance of two people for bed mobility.

On January 14, 2015, PSW #S104 and PSW #S105 reported to RN #S110 that Resident #1 was found at 0445 on the third round of the night shift, sleeping on a bedpan which had been in place since the previous evening shift, sometime between 1900 and 2000. His/her call bell was out of reach, wedged between the siderails but his/her personal alarm was clipped in place. Resident #1 was immediately removed from the bedpan and RN #S110 completed pain and skin assessments. The Resident's skin on was marked and reddened. The four PSWs were disciplined by the home.

In an interview on April 1, 2015, the DOC and Administrator confirmed that the appropriate police force was not notified as they did not think that the incident would result in criminal charges. [s. 98.]

2. Re: Log #O-000955-14
A review of the healthcare record and Critical Incident Report #2686-000007-14 indicated that Resident #2 has multiple comorbidities.

On September 2, 2014, Resident #2 was observed crying in the hallway outside his/her room. The Resident told RN #S109 that PSW #S108 had shut the door in his/her face when he/she was trying to get to her room and later denied doing so in a scolding manner. The DOC was notified because of the Resident's level of distress.

In an interview with the DOC on April 1, 2015, she confirmed that PSW #S108 was subsequently disciplined by the home. The DOC and Administrator confirmed that the appropriate police force was not notified as they did not think that the incident would result in criminal charges. [s. 98.]

Issued on this 1st day of May, 2015

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

Original report signed by the inspector.