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

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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
Sep 15, 2015	2015_365194_0021	O-002380-15	Resident Quality Inspection

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

CHANTAL LAFRENIERE (194), AMBER MOASE (541), JESSICA PATTISON (197), MARIA FRANCIS-ALLEN (552), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 25, 26, 27,28, 31 & September 1, 2, 3, 4, 2015

Inspected as well during the Resident Quality Inspection (RQI) were the following: Complaint Logs# O-001941-15, O-002537-15, Critical Incident Log # O-001777-15, O-001995-15,O-002182-15 and O-002523-15

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Registered Nurse(RN), Registered Practical Nurse(RPN), Personal Support Worker(PSW), RAI Coordinator, Environmental staff, Environmental Service Manager(ESM), Housekeeping staff, families and Residents.

Also completed was a tour of the building, review of relevant policies, clinical health records for identified residents, minutes of Family and Resident Councils and Educational records for staff. Observed Infection Control practices, Medication administration, dining services, resident living areas and resident/staff interaction during the provision of care

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. Log #O-002182-15

The licensee has failed to ensure that the staff and others involved in the different aspects of care for Resident #41 collaborate with each other in the development and implementation of the plan of care, so that the different aspects of care are integrated and are consistent with and complement each other.

The plan of care for Resident #41 indicates that resident requires two staff assistance and total care to be provided for toileting.

Resident #41 was assisted by two staff to bed and PSW #115 partially assisted the resident with toileting care at the residents request. Resident #41 was found approximately two hours later with toileting care uncompleted. Resident #41 was assessed to have a change in skin condition at the time of the incident.

During the licensee's internal investigation it was indicated that PSW #115 did not report to any other PSW's or Charge RN that Resident #41 would require further assistance with toileting care. [s. 6. (4) (a)]

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 by ensuring that staff and others involved in the different aspects of care of Resident #41 collaborate with each other in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the physical devices (seat belt)for Resident #22 and #7 were applied in accordance with the manufacturer's instructions

Review of the "Shoppers home health care - use & care of wheelchair hip belts" indicates;
-The most common wheelchair hip belts are "seat belts and positioning belts"
-common practice is to allow just enough space for two fingers to fit between the hip belt and the person's body, at any one point along the belt.

Resident #22 was observed sitting in a wheelchair in the lounge with a front closing seat belt in place. The seat belt was applied with a 4 finger width gap between the resident's body and the seat belt. Resident #22 when asked by inspector was unable to unfasten the seat belt.

The plan of care identifies Resident #22 at high risk for falls, when attempting to stand. Resident #22 was also observed to foot propel the wheelchair. The foot propelling and attempts to stand while in wheelchair place the resident at risk for injury, when seat belt is not properly applied.

Resident #7 was observed with a front closing seat belt applied with a greater than 4 finger width noted between the seat belt and the resident's body. Resident #7 when asked by inspector was unable to unfasten the seat belt.

During interview PSW #118, #119 indicated that they applied the seat belt to Resident #7 and did not tighten it. PSW #118 indicated to inspector that the Resident #7 was restless when in the wheelchair and needed to be repositioned by staff. [s. 110. (1) 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 by ensuring that staff apply the physical devices for Resident #22 and #7 in accordance with manufacturer's instructions., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training related to application, use and potential dangers of physical devices was provided to direct care staff.

During an interview PSW #118, #119 and #120 indicated that they did not receive training on application, use and potential dangers of physical devices.

PSW #118 and #119 were asked if they were aware of the proper application of seat belts and both staff replied that they were not.

During an interview Administrator and RAI coordinator indicated that the home was not providing training for staff related to application, use and potential dangers of physical restraints. [s. 221. (1) 5.]

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 by ensuring that staff who apply physical devices or who monitor residents restrained by physical devices, receive annual training in the application, use and potential dangers of these physical devices., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)8 in that a meal was not served course by course.

On an identified date, a meal was observed in the large dining room.

Resident #28 was given a main entree while the resident was still eating the soup. At the same time, Resident #10 was also provided with a main entree while a staff member was still providing feeding assistance with the soup.

Resident #32 was provided with a dessert while staff was still providing feeding assistance with the main entree.

Resident #27 was still eating a main entree and the dessert, lemon sorbet, had been left on the table to the side. By the time Resident #27 got to the dessert it had melted.

Review of the plans of care for the Residents #27, #28 and #32 did not provide specific interventions to support that the residents required to have courses provided together during meal service. [s. 73. (1) 8.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Log #O-002182-15

The licensee has failed to ensure that Resident #41's Substitute Decision Maker (SDM) was immediately notified of the outcome of the home's internal investigation into the allegations of abuse or neglect.

On an identified date, Resident #41 was assisted to bed and partially assisted with toileting care by PSW #115. Staff found Resident #41 with toileting care uncompleted, approximately two hours later.

During interview Administrator indicated that the SDM for Resident #41 was not notified of the results of the neglect investigation conducted by the home, immediately upon the completion. [s. 97. (2)]

WN #6: 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).

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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident was taken to hospital.

Related to Log # O-001777-15

A critical incident report (CIR) was received fourteen days after Resident #05 was transferred to hospital post fall. The CIR indicated the resident had an injury and required medical interventions the following day. The resident returned to the home on four days

after the fall.

Review of progress notes for Resident #05 indicated an entry on the day of the fall, that the hospital was contacted and the resident's condition had been updated.

Interview with the Administrator and the DOC confirmed the home did not report the incident to the Director when there had been a significant change in the Resident #05's condition assuming that when the CIR was initiated six days after the fall, the Ministry of Health and Long Term Care (MOHLTC) would have access to the CIR.

The Director was not notified of the incident until the CIR was submitted fourteen days of the resident's transfer to the hospital and confirmation of injury. [s. 107. (3)]

2. The licensee failed to 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):
3. A missing or unaccounted for controlled substance.

Log# O-001995-15

A CIR was submitted to the Director twelve days after the identification of missing narcotics. On an identified date, during the narcotic count, it was discovered by RN #105 and RPN #117 that there was a broken ampule narcotic in the package. The Director of Care was notified of the incident and immediately called the Administrator. The OPP was informed of the incident the following day.

During an interview the Administrator explained the CIR was initiated the following day, but was not submitted to the Director, until twelve days later.

The home has failed to comply with the legislation that indicates notification of missing or unaccounted controlled substance should occur within one business day. [s. 107. (3) 3.]

Issued on this 15th day of September, 2015

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

Original report signed by the inspector.