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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 10, 2016	2016_328571_0016	013432-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

PATRICIA MATA (571), BAIYE OROCK (624), JULIET MANDERSON-GRAY (607)

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): May 24, 25, 26, 27, 30, 31, June 1, 2, 3, 6 and 7, 2016.

The following Critical Incident Logs were inspected:
026717-15 related to resident to resident sexual abuse
031149-15 related to staff to resident neglect
034251-15 related to staff to resident neglect
In addition, Complaint Log #017115-16 related to staff to resident abuse was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, RAI Co-ordinator, Environmental Service Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Physiotherapist, Environmental Services Aid, Resident and Family Council members, family members and residents.

In addition, resident and staff interactions were observed, clinical health records were reviewed, investigation notes, administrative records and policies.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
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
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident related to resident #011.

Resident #011 was noted to have had several falls.

A review of the plan of care revealed that the resident had identified interventions in place to minimize falls and decrease risk of injury.

Resident #011 was observed on June 1 and 2, 2016. On both occasions, the identified intervention were not in place.

In an interview, PSW #121 confirmed that resident #011 did not have the identified interventions in place. RPN #122 confirmed that the resident's identified interventions were on hold as for a specified reason, and the plan of care was not updated to reflect that the identified interventions are not in place.

Therefore the licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident #011. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care for resident #033 set our clear directions to staff.

Re: Log #031149-15:

A Critical Incident (CI) was submitted to the MOHLTC on a specified date related to neglect of resident #033 by staff.

A review of the progress notes and the CI indicated that a specific intervention was to be in place on a specified date regarding the care of resident #011. RPN #115 wrote this intervention in small writing at the bottom of communication notes that staff are to review during report but failed to inform the Registered Nurse of the direction. This intervention was not documented any where else in the plan of care.

In an email to the Administrator dated November 2015, Charge RN #132 indicated that on a specified date, PSW #103 had asked for clarification about the intervention and requested that the note put in the communication notes by RPN #115 be made larger so staff would be aware of the proper care for resident #033; this was not done. In addition, the RN #132 was not aware of the specific intervention as the note in the communication book was written on October 2015.

A record review indicated that the intervention was not implemented for eight days therefore causing resident #033 to have altered skin integrity.

Therefore, the licensee failed to ensure the plan of care provided clear directions to staff regarding the care of resident #033. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care for resident #009 was based on an assessment of the resident and the resident's needs and preferences related to shaving.

Resident #009 requires assistance with activities of daily living.

During an interview, the SDM for resident #009 indicated that the resident is not provided with a specific care need.

A review of the clinical record for resident #009 indicated the following:
-in March 2016, the resident was provided with the specific care need six days in the month-one day was documented refused
-in April 2016, the resident was was provided with the specific care need six days in the month-one day was documented as refused
-in May 2016, the resident was was provided with the specific care need two days in the

month-four days were documented refused

In an interview, PSW #103 and #107 indicated that they both provide the specific care need to resident #009 when they are assigned to care for the resident.

After review of the plan of care, no evidence of the resident's need or preferences for the specific care need were found.

Therefore, the licensee failed to ensure the plan of care for resident #009 was based on an assessment of the resident and the residents needs and preferences. [s. 6. (2)]

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 with ensuring that for each resident, the plan of care provides clear directions to staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Registered Nurse in Charge #128 immediately reported sexual abuse of a resident by another resident to the Director (MOHLTC).

Re: Log #026717-15:

A Critical Incident (CI) was submitted to the MOHLTC on a specified date related to an incident of sexual abuse of resident #014 by resident #011.

The CI indicated that on a specified date and time, resident #011 PSW #128 and #129 observed resident #011 stroked the leg of resident #014 causing the resident to "feel uncomfortable". Resident #014 was advised to leave the area as resident #011 refused to move. When the staff were escorting resident #014 away from resident #011, resident #011 began to follow the resident. RN #128 also intervened.

In addition, review of the progress notes for resident #011 further indicated that on a later specified date, resident #011 was observed in appropriately touching another resident.

In an interview, the Administrator indicated that neither incident had been reported to the Director.

Therefore, the licensee failed to ensure that the Director was immediately informed of the incidents of sexual abuse. [s. 24. (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 to ensure that staff are immediately reporting the suspicion of abuse and the information upon which it is based immediately to the Director (MOHLTC), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that symptoms indicating the presence of infection in resident #028 and #003 were monitored on every shift when the residents had symptoms of a respiratory infection.

A review of resident #028's health records revealed that the resident was identified as having an infection during a specified time period. A review of the progress note indicated that on a specified day, resident #028 was identified to have symptoms of infection.

A review of the progress notes for resident #028 for a specified time period indicated that symptoms of respiratory infections were not documented for 14 days for the specified time period.

A review of resident # 003's health records revealed that the resident was identified as having an infection for a specified time period. A review of the progress notes indicated that on a specified time period the resident was diagnosed with a infection. Symptoms of infection were not documented over a seven day period that the resident was being treated.

In an interview with RN #119 and RN #120 and the DOC, all three indicated that the expectation is that resident symptoms are to be monitored on every shift when a resident has symptoms that are indicative of the presence of a possible infection. They were unable to provide documentation to support that monitoring of symptoms of infection had been done for either resident.

Therefore, the licensee failed to ensure that symptoms of respiratory infection were monitored on every shift. [s. 229. (5) (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 with ensuring that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to keep the personal health information of residents confidential.

According to the LTCHA 2007, s. 79 (1) the licensee is required to post required information in a conspicuous and easily accessible location in the home. Section 79 (3) (k) requires that copies of the inspection reports from the past two years be posted. In addition, when homes receive their Licensee Inspection Reports from the MOHLTC, they are instructed in writing not to post the Licensee copy of the report but rather, post the Public copy which has all personal health and identifying information removed.

During a tour of the home that was conducted on May 24, 2016, Licensee copies of the following reports, containing personal health information of several residents, was found posted on the bulletin board of the home and accessible to the general public:

Critical Incident System Inspection Report No 2016_178624_0001
Follow Up Inspection and Order Report No 2015_346133_0046
Resident Quality Inspection Report and Orders No 2014_365194_0004

During an interview with the Administrator, she indicated that the Licensee Inspection Reports should not have been posted.

Therefore, the licensee failed to keep personal health information of residents confidential. [s. 3. (1) 11. iv.]

WN #5: 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 ensure that their Falls policy was complied with for resident #011, #003 and #002.

O. Reg. 79/10, s. 48 (1) 1. requires that every licensee ensure that a falls prevention and management program to reduce the incidence of falls and risk of injury be developed and implemented in the home.

Resident #011 was noted to have had falls on three specified dates.

Resident #003 was noted to have had falls on six specified dates.

Resident #002 was noted to have had falls on three specified dates.

The licensee's policy #CS-12.1 entitled "Resident Falls" under section 14 and dated January 2013, directs registered nursing staff to complete a post-fall assessment within 24 hours of a resident fall and provide it to the DOC for review. This assessment is to filed in the resident's clinical record.

After a review of the clinical records for resident #011, #003 and #002, no evidence of post fall assessments being completed on the above dates or within 24 hours of the falls for the aforementioned residents could be found.

In separate interviews, RPN #122 confirmed that a post fall assessment was not completed on the above identified dates for these residents. The Administrator confirmed that the expectations is that Post fall Assessments are completed immediately after a fall or within 24 hours of a resident having a fall and that she could not locate a post fall assessment for the above identified dates.

Therefore, the licensee failed to ensure that their "Resident Falls" policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident shower in the Tub room had at least two easily accessible grab bars.

During a tour of the home that was conducted on May 24, 2016, the inspector observed that the resident shower located inside the tub room had no grab bars. In an interview PSW #101 indicated that the shower is used by residents.

Therefore, the licensee failed to ensure grab bars were installed as per O. Reg. 79/10, s.14. [s. 14.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an admission care conference was held within six weeks of the admission for resident #011.

Resident # 011 was admitted to the home on a specified date.

The Substitute Decision Maker for resident #011 indicated in an interview on May 27, 2016, that they had not been notified of a care conference.

In separate interviews, the DOC indicated that all records of care conferences are kept in a binder by RPN #115. RPN #115 indicated that a care conference was not held for resident #011.

After a review of the binder containing care conference records, no record of a care conference for resident #011 could be found. [s. 27. (1)]

2. The licensee has failed to ensure that an admission care conference was held within six weeks of the admission for resident #009.

Resident # 009 was admitted to the home on a specified date.

The Substitute Decision Maker for resident #009 indicated in an interview on May 26, 2016, that they had not been notified of a care conference.

In separate interviews, the DOC indicated that all records of care conferences are kept in a binder by RPN #115. RPN #115 indicated that she communicates the the SDM of resident #009 regularly but a formal care conference was not held.

After a review of the binder containing care conference records and progress notes, no record of a care conference for resident #009 could be found.

Therefore, the licensee failed to ensure that a care conference was held within six weeks of admission for resident #011 and #009. [s. 27. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

A record review indicated that two identified concerns related to the dietary department were raised during the family council meetings:
-June 23, 2015, the concern was that toast at breakfast is served too cold
-January 25th, 2016, the concern was that thickened fluids are served too thick

A review of the records could not locate written responses to the above identified concerns provided to the Family Council.

In an interview, the Administrator confirmed that there should have been written responses to the above identified concerns. [s. 60. (2)]

Issued on this 13th day of June, 2016

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

Original report signed by the inspector.