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
Jul 10, 2017	2017_670571_0002	007663-17	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), JENNIFER BATTEN (672)

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 17, 18, 19, 23, 24, 25, 26, 29, and 30, 2017.

The following logs were also inspected:
Critical Incident logs
017424-16 re: alleged staff to resident abuse
003675-17 re: alleged staff to resident neglect
006322-17, 007381-17 and 009250-17 re: alleged resident to resident physical abuse;
and Complaint log # 007792-17 re: alleged resident to resident physical abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Manager of Nutrition Services and Environment, RAI Co-ordinator, BSO (Behavioural Support Ontario) Lead, Registered Practical Nurses (RPN), Registered Nurses (RN), Personal Support Workers (PSW), residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
4 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. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident's needs.

A review of the clinical health records by Inspector #571 indicated the following for resident #002:

-on a specified date- RN #106 indicated that during and after a meal, resident #002 was having difficulty swallowing and when RN #106 discussed this with the SDM of resident #002, the SDM indicated that the resident had the same symptoms previously when the resident was sent to the hospital and treated for a specific diagnosis-RN #106 changed resident #002's diet until the specific diagnosis had been ruled out
-one day later-RN #107 documented that the resident had respiratory difficulties
-on the same day-RPN #105 documented that the resident was given medication at a specified time and had trouble swallowing the medication. One hour and 15 minutes later, RPN #105 administers more medication. The resident was unable to keep the medication down. RPN #105 observed specified symptoms. The Nurse Practitioner (NP) was called.
-on the same day- the NP documented that in the past the resident had been diagnosed with a specific problem and treated at the hospital- the NP assessed resident #002 and sent the resident to the hospital for immediate treatment

-later the same day-resident #002 returns from hospital without treatment with directions to receive small sips of fluids only
-the next day- the resident is sent back to hospital for diagnosis and treatment as the resident continues to exhibit symptoms

In an interview on May 24, 2017 with Inspector #571, RN #106 indicated that resident #002 had a history of a specified diagnosis that would contribute to the exhibited symptoms. The RN changed the resident's diet but did not notify the physician.

In an interview on May 25, 2017 with Inspector #571, RN #114 indicated working the day after RN #106 changed resident #002's diet. RN #114 did not question the nursing intervention of the change of diet for resident #002 despite knowing the resident had a history of the specified diagnosis. The doctor was not notified. The NP was notified later in the shift by the RPN.

Therefore, the licensee failed to ensure that resident #002's plan of care was based on an assessment of the resident's needs when RN #107 and #114 suspected that the resident had a specified diagnosis. [s. 6. (2)]

2. The licensee failed to ensure that when a resident is reassessed and the plan of care is revised because the care set out in the plan has not been effective and different approaches have been considered in the revision of the plan of care.

Re: Log #009250-17:

A Critical Incident (CI) involving an allegation of resident to resident physical abuse was submitted to the Director. The CI indicated that on a specified date and time, resident #020 was noted to be absent from his/her room. Staff began to immediately search for resident #020. Resident #016 was observed upset and indicated that resident #020 had physically abused him/her. Staff entered resident #016's room and observed resident #020.

A review of the clinical health record for resident #020 indicated that the resident had inappropriate responsive behaviours. A review of the progress notes and administrative records for a specified two month period indicated that staff had implemented a specified intervention in order to prevent resident #020 from displaying inappropriate responsive behaviours toward other residents.

On a specified date and time, the specified intervention had been discontinued for a specified period of time and other interventions were put into place.

On a specified date and time, nine days after the specified intervention had been discontinued, RN #117 documented that resident #020 was observed coming out of a co-resident's room. The resident was redirected and monitored.

On a specified date and time, 15 days after the specified intervention had been discontinued, RN #107 documented that staff responded to a co-resident yelling at resident #020 as resident #020 was in the wrong room. RN #107 further documented that no immediate action was taken as resident #020's unpredictability and physically responsive behaviours were not new, and all steps had already been implemented.

On a specified date and time, approximately one month after the specified intervention had been discontinued, resident #016 was found to be upset and alleged that resident #020 had physically abuse him/her.

In a telephone interview on June 9, 2017, BSO RPN #100 indicated to Inspector #571 that a specified intervention for resident #020 was discontinued on a specified date. This was a multidisciplinary decision involving the physician from the Psychiatric Assessment Services for the Elderly (PASE). Other interventions were put into place to protect other residents from resident #020's responsive behaviours. BSO RPN #100 indicated that additional interventions were not considered after the two specified incidents of resident #020 being found in or coming out of another resident's room. The specified intervention was only reinstated approximately one month later, after resident #020 physically abused resident #016.

Therefore, the licensee failed to ensure that when resident #020 was reassessed and the plan of care was revised because the care set out in the plan has not been effective, different approaches were not considered in the revision of the plan of care. [s. 6. (11) (b)]

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 the plan of care for resident #002 is based on an assessment of the resident and the resident's need; and by ensuring that when resident #020 is reassessed and the plan of care reviewed and revised because the care set out in the plan has not been effective, different approaches are considered, 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 :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone, shall immediately report the suspicion and the information upon which it is based to the Director.

Re: log 017424-16:

A Critical Incident (CI) was reported to the Director regarding alleged emotional abuse of resident #028 by staff members occurring on a specified date.

A review of the progress notes indicated that on a specified date and time, resident #028 reported to RN #107 that two staff who had been working the day before, had been "mean and nasty" and called the resident a specified name.

The incident of alleged emotional abuse of resident #028 was reported through the CI system by the Administrator when she became aware of the allegation on two days later.

Therefore, the licensee failed to ensure RN #107 immediately reported, to the Director, an allegation of emotional abuse that allegedly occurred on a specified date when the RN was informed of the allegation. [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 by ensuring that a person who has reasonable grounds to suspect that 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 has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #023 has multiple medical diagnosis including a specified medical diagnosis.

On a specified date, resident #023 was noted to not be feeling well, and was experiencing a specified symptom. The resident was transferred to hospital for further assessment. Resident #023 was diagnosed with a specific medical diagnosis. Resident #023 was stabilized in hospital and transferred back to the home. That evening, resident #023 was administered a specified drug that had been discontinued at the hospital. A Medication Incident Report was completed. According to the Medication Incident Report, the medication was still active in the eMAR (electronic Medication Administration Record) for Agency RN #118 to see, the medication reconciliation had not been completed upon resident #023's return from hospital, and that Agency RN #118 only reviewed the hospital discharge papers for resident #023 after the medication pass had been completed.

Inspector #672 interviewed the DOC (Director of Care) about this medication incident, and the DOC indicated that the fact that the medication reconciliation had not been completed should have been passed along during shift report, but it had not been, which contributed to Agency RN #118 believing the medications which appeared on the eMAR system were up to date and accurate. The DOC stated that completion of the medication reconciliation was the responsibility of the RN on duty when the resident returned from hospital. Inspector #672 also interviewed RN #104, who acknowledged she was working on the shift that resident #023 returned from hospital, and that the medication reconciliation had not been completed prior to her leaving at the end of her shift.

Review of the home's policy on medication reconciliation, from the Pharmacy Policy and Procedure Manual for LTC Homes, Policy 7-2, dated February 2017, indicated that the home was to follow the BOOMR Method, which stated that upon resident admission or transfer back into the home, there is supposed to be a "Trio Call" between the nurse, the

MD/NP and the Pharmacist, to discuss findings, medication discrepancies, clinical concerns and determine prescriber orders before the resident arrives at the home.
Policy 7-4, Hospitalization of Residents, states the following:
4. When a resident has been hospitalized for more than 72 hours, all medications including topical preparations, liquids, eye preparations, etc. are to be set aside [quarantined] pending approval of new orders by the physician after a medication reconciliation is completed.
Policy 7-5, Readmission of Residents from Hospital, states the following:
5. Ensure MAR accurately reflects all new and changed orders
6. Review readmission orders carefully especially medications on hold during resident's stay in hospital. Hold orders will need to be discontinued or reactivated.

A review of the Discharge BPMH (Best Possible Medication History)/Prescription sheets from the hospital revealed that the specified drug had been discontinued.

The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions are analyzed, and that corrective actions were taken as necessary.

Review of medication incident reports for the period of three months was completed by Inspector #672.

As stated in WN # 3, resident #023 was sent to the hospital on a specified date and treated for a specified diagnosis. A medication error occurred when resident #023 returned from the hospital.

In an interview, the DOC indicated to Inspector #672 that it was within the role of the DOC to oversee the medication program in the home, and follow up on all medication incidents. Inspector #672 asked the DOC if she had followed up with RN #118, or if any corrective action had been taken to prevent a similar incident from occurring in the future. The DOC indicated that this did not occur. Review of the Medication Incident Report did not reveal anywhere that the incident had been analyzed, nor that any corrective action had been taken.

Resident #022 has an order for a specified medication to be given at specified times. Review of the Medication Incident Report revealed that resident did not receive the medication as ordered, although the nurse on the shift had signed for the medication in the eMAR system as given. Inspector #672 interviewed the DOC about this medication incident, and asked the DOC if she had followed up with RN #107, or if any corrective action had been taken to prevent a similar incident from occurring in the future. She indicated that this had not been done. Review of the Medication Incident Report did not reveal anywhere that the incident had been analyzed, nor that any corrective action had

been taken.

Resident #006 has specified medical diagnoses. Resident #006 receives several medications. Review of the Medication Incident Reports indicated that on a specified date and time, the nurse had found the medication strip from a specified time still had medication in it, although the medication had been signed for as given on the eMAR system. Inspector #672 interviewed the DOC about this medication incident, and asked the DOC if she had followed up with the nurse, or if any corrective action had been taken to prevent a similar incident from occurring in the future, and she indicated that she had not. Review of the Medication Incident Report did not reveal anywhere that the incident had been analyzed, nor that any corrective action had been taken.

The licensee has failed to ensure that the above medication incidents and adverse drug reactions are analyzed, and that corrective action is taken as necessary. [s. 135. (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 by ensuring that all medication incidents and adverse drug reactions are analyzed and that corrective actions are taken as necessary, to be implemented voluntarily.

Issued on this 11th day of July, 2017

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

Original report signed by the inspector.