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
Dec 31, 2019	2019_640601_0027	023179-19	Complaint

Licensee/Titulaire de permis

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

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 6th Line East CAMPBELLFORD ON K0L 1L0

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

KARYN WOOD (601)

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): December 16, 17, 18, 19, 20 and 23, 2019.

The following intake was completed in this complaint inspection:

Log #023179-19 was related to an injury with a change in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator/Life Enrichment Coordinator, the Director of Care (DOC), Registered Nurse (RN), RAI-MDS Coordinator, Registered Practical Nurses (RPN), Personal Support Workers (PSW) and a family member and resident.

The Inspector also reviewed residents health records, the licensee's relevant policies and procedures, and observed the delivery of resident care and services including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (2) The duties in subsection (1) do not apply where the resident is absent from the home, unless the resident continues to receive care or services from the licensee, staff or volunteers of the home. 2007, c. 8, s. 19 (2).

Findings/Faits saillants :

1. The licensee has failed to protect resident #001 from neglect while the resident was absent from the home and required staff supervision.

O. Reg. 79/10, s. 5, defines “neglect” as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was received by the Director on a specified date related to resident #001 sustaining an injury while the resident was absent from the home and required staff supervision.

A Critical Incident Report (CIR) was submitted to the Director related to resident #001 sustaining injuries, while absent from the home with the supervision of staff on a specified date and time. The CIR further indicated the Administrator/Life Enrichment Coordinator and the Leisure Assistant (LA) had left the resident unsupervised while the resident was absent from the home.

During an interview on a specified date, the Administrator/Life Enrichment Coordinator indicated to Inspector #601 that resident #001 had been left unsupervised by staff. The Administrator/Life Enrichment Coordinator further indicated the licensee’s specified policy directs for residents to not be left unattended while they are absent from the home.

The licensee did not protect resident #001 from neglect while the resident was absent from the home and required staff supervision, as the resident sustained specified injuries when they were left unsupervised on a specified date during their absence from the home. [s. 19. (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 to ensure resident #001 is protected from neglect while the resident is absent from the home and requires staff supervision
, to be implemented voluntarily.***

Issued on this 2nd day of January, 2020

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

Original report signed by the inspector.