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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Public Copy/Copie du rapport public

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_0028	020171-19	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:

A log was related to a specified symptom management.

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

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:
Dignity, Choice and Privacy
Pain
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. 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 has failed to ensure that residents personal health information (within the meaning of the Personal Health Information Act, 2004) was fully respected and promoted the resident's right to have their personal health information kept confidential.

The Director received an anonymous complaint on a specified date, regarding the management of resident #003's specified symptom.

During a telephone interview on a specified date, the complainant indicated to Inspector #601 that resident 003's personal health information had been posted on a public board inside the home. They further indicated that a member of the public had approached them about the specified report. The member of the public had noticed resident #003's initials and that the resident was taking a specified medication. The complainant also indicated it would be easy to identify residents by initials as there were 43 residents residing in the home.

On a specified date, Inspector #601 observed the public board inside the home and the specified report had been posted, on a specified date. Inspector #601 reviewed the specified report and there was personal health information for residents, who had been identified by their initials in the report.

During an interview on a specified date, the Administrator indicated the specified report had been posted on the public board, on a specified date and the residents initials had been used to identify the residents. The Administrator indicated they didn't realize the resident initials would identify the residents and their personal health information. The Administrator further indicated the specified report will be an internal document and will no longer be posted for the public to view.

The licensee did not ensure that residents personal health information was fully respected and promoted the resident's right to have their personal health information kept confidential. [s. 3. (1) 11. iv.]

Issued on this 8th day of January, 2020

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

Original report signed by the inspector.