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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Nov 15, 2021	2021_947752_0003	003905-21	Critical Incident System

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

LUCIA KWOK (752), KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 18, 19, 20, and 21, 2021

A Log was related to a fall resulting in significant change.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Clinical Care Coordinator (CCC), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).
The inspector(s) conducted a tour of the home, observed the provision of care, and resident and staff interactions. The inspector(s) reviewed pertinent clinical records, and relevant policies and procedures, Long-Term Care Home's (LTCH) investigation notes, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' plan of care included clear directions to staff related to their fall prevention interventions.

The CCC stated that a resident's plan of care included their electronic records, Point of Care (POC) sheets, and closet kardex. They further stated that the closet kardex provided a snapshot of a resident's care needs, documented a resident's fall risk, and their fall prevention interventions.

a) A resident had sustained a fall resulting in significant change in their status. The resident's closet kardex documented different fall prevention interventions than their closet kardex. During an interview, PSW #116 stated they were not sure of the fall prevention interventions in place for the resident. The CCC acknowledged that the resident's plan of care did not contain clear instructions for staff.

b) A resident's closet kardex documented their fall prevention interventions. Their electronic care plan documented contraindicated information regarding their falls prevention interventions. Inspector #752 observed that the resident's fall preventions interventions was not in accordance to their closet kardex nor their electronic care plan.

c) A resident's closet kardex and electronic care plan documented different falls preventions interventions. Inspector #752 observed that resident did not have their falls prevention intervention in place.

The gap in clear directions in the residents' plan of care increased the risk for falls as appropriate fall preventions interventions were not implemented.

Source: Observations conducted in the home; Interviews with CCC, PSW #116 and other staff; Residents' closet kardex, electronic care plan. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program, specifically, assisting residents with hand hygiene after meal, and universal masking specified in Directive #3.

a) A meal observation was conducted. After the meal service, there was no direct care staff present in the dining room/lounge to assist the residents with hand hygiene. Inspector #752 observed residents exit the dining room/lounge without performing hand hygiene and they were not observed to have received assistance in hand hygiene from staff.

Two residents stated that sometimes after meal service, hand hygiene was not provided.

The DOC/ IPAC lead and dietary aide #113 stated that direct care staff were to assist residents with hand hygiene after and before meals.

The residents were at minimal risk for transmission of infection when staff failed to offer and assist residents with hand hygiene after meal.

Sources: Observations during lunch meal; Interviews with DOC, dietary aide #113, and residents.

b) The Chief Medical Officer of Health (CMOH) implemented Directive #3, which had been issued to LTCHs, and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs.

The following observations were made in the home:

-During meal service, RPN #111 was observed administering medication to residents in the small dining room/lounge with improperly applied personal protective equipment (PPE).
-RPN #111 was observed to be in a resident room conversing with a resident in close proximity with improperly applied PPE.
-PSW #121 was seen at the nursing station standing with other staff member during shift report with improperly applied PPE.

The DOC/ IPAC lead stated that staff were to have their masks applied properly for the entirety of their shift except during their breaks.

The observations demonstrated that that there were inconsistent IPAC practices from the staff of the home. There was minimal risk of harm to residents associated with these observations because by not adhering to the home's IPAC program and the measures set out in Directive #3, there could be possible transmission of infectious agents, including the COVID-19 virus.

Sources: Observations made throughout the home on October 19, and 20, 2021; Interviews with DOC and staff; Directive #3, dated July 16, 2021. [s. 229. (4)]

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 all staff participate in the implementation of the Infection Prevention and Control (IPAC) program, to be implemented voluntarily.

Issued on this 22nd day of November, 2021

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

Original report signed by the inspector.