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
Nov 2, 2021	2021_885601_0017	008182-21	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): October 18, 19, 20, and 21, 2021.

The following intake was completed in this Complaint Inspection:

A log related to allegations of staff to resident abuse not being immediately reported to the police and care concerns related to improper medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument/Clinical Care Coordinator (RAI/CCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Ontario Provincial Police Sergeant and residents.

The inspector also reviewed resident health care records, internal investigation records, policies, observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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	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 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 the medication policy in place under O. Reg. 79/10 s. 114 (1) when every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents was complied with.

The Ministry of Long-Term Care received a complaint from a Sergeant of the Ontario Provincial Police (OPP) regarding allegations of improper care related to agency RN's medication administration practices. A PSW reported allegations of staff to resident improper care related to medication administration to the Administrator and Director of Care (DOC) by email. The allegation by the PSW indicated that the RN did not properly administer the resident's medication. The RN did not document the administration of the medication in the resident's electronic Medication Administration Record (e-MAR). According to the DOC, the RN had denied the allegations of improperly administering the medication and that the RN should have documented the administration of the medication in the resident's e-MAR, as per the licensee's medication pass policy. The resident was placed at risk of receiving the same medication by a different nurse when there was no record that the medication had already been administered by the RN.

Sources: The Medication Pass policy, a resident's progress notes and e-MAR, review of emails, and interviews with a PSW, DOC, Administrator, and the Sergeant from the OPP. [s. 8. (1) (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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, 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 the person having reasonable grounds to suspect improper care of a resident, that resulted in harm or a risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

The Ministry of Long-Term Care received a complaint from a Sergeant of the Ontario Provincial Police (OPP) regarding allegations of improper care related to medication administration. A PSW reported allegations of staff to resident improper care related to medication administration to the Administrator and Director of Care (DOC) by email. The allegation by the PSW indicated that an RN did not properly administer a resident's medication. The Ministry of Long-Term Care information line was not notified of the allegations. The Administrator and DOC both acknowledged a Critical Incident System (CIS) report was not completed and the Director was not notified of the allegations. The allegation of improper care should have been immediately reported to the Director to allow for proper follow up into the allegations.

Sources: Review of resident's progress notes, review of emails, medication administration records, interviews with the Administrator, DOC and Sergeant from the OPP. [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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of an alleged, suspected or witnessed incident of abuse of a resident.

The Ministry of Long-Term Care received a complaint from a Sergeant of the Ontario Provincial Police (OPP) that the police were not immediately notified when there were allegations of abuse towards a resident. A PSW reported allegations of staff to resident abuse to the Director of Care (DOC) by email and the email was received by the DOC two days following the incident. The OPP were notified of the allegations of abuse by email when the DOC became aware, two days after the incident occurred. The Sergeant indicated the allegation of abuse should have been immediately reported to the police and the email received by the police to report the allegations of abuse did not allow for an immediate investigation. The Administrator and DOC both acknowledged the police were not immediately notified of the allegations of abuse due to the PSW communicating the allegation of abuse by email to the DOC rather than directly contacting the management in the home.

Sources: Review of Critical Incident System, review of emails, interviews with the Administrator, DOC and Sergeant from the OPP. [s. 98.]

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 shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #4: 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 had failed to ensure that no drug was administered to a resident unless the drug was prescribed for the resident.

The Ministry of Long-Term Care received a complaint from a Sergeant of the Ontario Provincial Police (OPP) regarding allegations of improper care related to medication administration practices by an agency RN. A resident was prescribed a medication that could be administered once daily as needed to manage a responsive behaviour. On two occasions, the agency RN and RN #108 documented and administered the same once daily medication to manage a responsive behaviour. The RAI/CCC and the DOC both confirmed that on both occasions, the resident received a medication that was not prescribed for them when the second dose was administered by RN #108. They further indicated that the agency RN should have documented they had administered the resident’s once daily as needed medication for responsive behaviours on the resident’s e-MAR. According to the RAI/CCC, the e-MAR tracks the time intervals between doses of medication and would have alerted RN #108 that the once daily medication had already been administered on the two occasions, if the agency RN had documented according to the medication policy. There was a risk the resident could have had a negative outcome when the medication was given twice on the same day and was prescribed to be administered once daily, as needed to manage a responsive behaviour.

Sources: A resident's progress notes, physician orders, e-MAR, PRN Administration and Documentation policy, interviews with the RAI/CCC, DOC, and Sergeant from the OPP. [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 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, to be implemented voluntarily.

Issued on this 23rd day of November, 2021

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

Original report signed by the inspector.