Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date **July 6, 2022**
Inspection Number 2022_1187_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

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

Long-Term Care Home and City
Burnbrae Gardens, Campbellford

Lead Inspector Choose an item.
Karyn Wood (601)

Additional Inspector(s)
Stephanie Fitzgerald (741726)
(Observed inspection)

Karyn L Wood
Digitally signed by Karyn L Wood
Date: 2022.07.07 15:50:58 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 25, 26, 27, 31, June 1, 2, 3, and 6, 2022.

The following intake(s) were inspected:

Four logs related to allegations of resident-to-resident abuse.

A log related to a fall that resulted in an injury to a resident.

The following Inspection Protocols were used during this inspection:

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Falls Prevention and Management

Written Notification Falls prevention and management
NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 79/10, s. 49 (2)

The licensee has failed to ensure that a resident was assessed with a post fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director following an unwitnessed fall that resulted in the resident sustaining an injury.

Record review and staff interviews identified the resident was a high risk for falls and had serval falls the month prior with no injuries. The resident's progress notes indicated the resident had an unwitnessed fall in the month prior. The agency RPN documented the post fall examination in the resident's progress notes and they did not complete a post fall assessment, as directed in the falls policy. According to the progress notes, the resident's post fall examination included a pain assessment, vital signs, range of motion to their extremities and that the resident was able to follow verbal commands. The specifically designed post fall assessment was not completed electronically. A neurological assessment was not documented, and the head injury routine (HIR) was not completed following the discovery of the resident.

The policy directed registered staff to document a resident's fall using the electronic post fall assessment and to complete HIR post unwitnessed fall to ensure the resident was monitored for signs of neurological changes.

The Administrator, Director of Care (DOC) and RAI/CCC acknowledged the falls policy was not followed and the RPN should have completed the post fall assessment electronically and initiated the HIR post fall monitoring when the resident had an unwitnessed fall.

The resident was at moderate risk when a post fall assessment was not completed as the contributing factors were not identified and an analysis of the fall was not completed. The resident was impacted as the HIR monitoring was not completed following an unwitnessed fall which could have led to delayed assessment and treatment for the resident.

Sources: A resident's progress notes, care plan, post falls assessments, Custom Assessment List, Fall Checklist, Medication/Treatment Administration Record, Shift to Shift Report Sheet, Committee Falls Minutes, Resident Falls and Post Fall Assessment policy, and interviews with PSW, RPN, RAI/CCC, Director of Care, and Administrator. (601)

Compliance Order [CO#001] Duty to protect
NC#002 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: **LTCHA, 2007, s. 19 (1)**

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee must be compliant with LTCHA, 2007, s. 19.

The licensee shall:

A) Review two residents' responsive behaviours, triggers and revise their plan of care to include interventions that will reduce the risk of harmful altercations between the two residents and other residents. Review both residents plan of care with direct care staff to ensure the interventions are implemented. Monitor the effectiveness of the revisions and keep a documented record of each revision to the plan of care.

B) Educate staff providing direct care to the two specified residents on implementing immediate interventions, including when and how to utilize the Dementia Observation System (DOS) policy. Keep a documented record of the education content provided to staff, including the individual who provided the education, those who attended, and the date of the training.

Grounds

Non-compliance with: LTCHA, 2007, s. 19 (1)

1)The licensee has failed to protect resident #005 from physical abuse by resident #001.

Physical abuse is defined under O. Reg. 79/10 as including the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

Resident #001 had responsive behaviours and had altercations with other residents. Resident #001 was physically aggressive with the RN when they attempted to redirect the resident. RPN #104 intervened by redirecting the resident down the hall.

There was a second physical altercation involving resident #001 later in the day that resulted in another resident sustaining a minor injury and was emotional upset due to resident #001's responsive behaviours.

Resident #001's plan of care included the Dementia Observation System (DOS) monitoring tool, and interventions to manage the resident when exhibiting behaviours. The DOS was incomplete, and there was no evidence of staff monitoring or shadowing the resident while exhibiting responsive behaviours, as specified in the plan of care. Staff interviews identified the resident was redirected to another area in the home following the first incident and could not recall implementing the additional interventions specified in the resident's plan of care.

Interventions to manage resident #001's responsive behaviours were not effective and did not prevent resident #001 from physically abusing resident #005.

Sources**:** CIS report, progress notes and care plans for both residents, and interviews RPN/RAI/CC, RPN, RN, PSW, RPN/BSO, and the Administrator. (601)

2) The licensee has failed to protect resident #001 from physical abuse by resident #004.

Rationale and Summary

Resident #004 and resident #001 both had responsive behaviours and resident #001 had several altercations with other resident's due to their responsive behaviours.

There was a verbal altercation between resident #004 and resident #001. Staff intervened by separating the residents and both residents remained calm.

There was a second altercations between the two residents later that day. According to the Critical Incident System (CIS) report and the Administrator, staff observed resident #004's responsive behaviour towards resident #001, that resulted in resident #001 sustaining a minor injury.

Resident #004's plan of care included the Dementia Observation System (DOS) monitoring tool, and interventions to manage the resident when exhibiting behaviours. Resident #004's plan of care was to keep the two residents' away from each other. The DOS was incomplete, and there was no evidence staff intervened prior to the altercation when the residents were both in the same place. Staff interviews and the care plan identified that resident #001's responsive behaviour towards resident #004 was known. RPN #104 indicated they could not recall being informed at the beginning

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of their shift that an altercation had occurred between resident #004 and resident #001, earlier in the day. Staff interviewed could not recall implementing the additional interventions specified in the resident's plan of care to manage their responsive behaviours.

Interventions to manage resident #004's and resident #001's responsive behaviours were not effective and did not prevent resident #004 from physically abusing resident #001.

Sources: CIS report, progress notes, and care plans for residents #004 and #001, and interviews RPN/RAI/CC, RPN, RN, PSW, RPN/BSO, and the Administrator.

This order must be complied with by September 2, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.