Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
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Original Public Report

Report Issue Date: May 15, 2024	
Inspection Number: 2024-1187-0001	
Inspection Type: Complaint Critical Incident (CI)	
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	
Long Term Care Home and City: Burnbrae Gardens Long Term Care Residence, Campbellford	
Lead Inspector Karyn Wood (601)	**Inspector Digital Signature** Karyn L Wood Digitally signed by Karyn L Wood Date: 2024.05.16 14:12:12 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29, 30, 2024 and May 1, 2, 3, 2024. The inspection occurred offsite on May 6, 2024.

The following intake(s) were inspected:
· An intake regarding a fall of a resident which resulted in a transfer to the hospital.
· An intake regarding a respiratory outbreak.
· An intake regarding allegations of an improper transfer of a resident.
· An intake regarding a complaint with allegations of staff to resident abuse.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary

A complaint was submitted to the Director regarding allegations of improper care. The complainant reported the resident experienced a medical condition and their specified vital sign level was below normal limits.

Registered staff and Personal Support Workers (PSWs) confirmed the resident

always required the use of a treatment and the resident would often remove the specified treatment. The Registered Nurse (RN) documented the incident when the resident had symptoms of a medical condition and was experiencing the specified vital sign level below normal limit. The RN and PSWs reported the resident had removed their treatment at the time of the incident. There was no documentation to support that the resident's vital sign levels were measured regularly or prior to the RN's assessment when the resident was experiencing the medical condition.

Registered staff were not consistently documenting the resident's vital sign levels or when the resident was receiving the specified treatment or removing their treatment.

The resident had a chronic health condition and failure to measure, respond, and document the resident's specified vital sign placed the resident at risk for medical complications.

Sources: Review of a resident's clinical health record including, digital physician orders, progress notes, written care plan, vital sign records, electronic Treatment Administration Record (e-TAR) and electronic Medication Administration Record (e-MAR), and interviews with staff. [601]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)
Reporting certain matters to Director
s. 28 (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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

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.

Rationale and Summary

A complaint was submitted to the Director regarding allegations of abuse that occurred when a resident was displaying responsive behaviours that resulted in the resident sustaining a minor injury.

The resident was known to have responsive behaviours. Record review, and interviews with PSWs, and the RN identified the resident was exhibiting responsive behaviours and staff transferred the resident to their mobility aide to maintain their safety. The resident sustained a minor injury following the incident.

An internal investigation was initiated following the allegation of improper care and the internal investigation determined the allegations were not substantiated. A CI

report regarding the allegations of abuse or a call to the Ministry's after-hours line was not found for the allegations of abuse. The DOC acknowledged a CI should have been submitted to the Director when they were made aware of the allegations.

The allegations of staff to resident improper care was not reported to the Director and further incidents could occur without proper follow-up.

Sources: A resident's clinical health records including, progress notes, written plan of care, documentation survey reports, internal investigation documents, and interviews with the DOC. [601]

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the falls prevention and management program to reduce the incidence of falls and the risk of injury for a resident was implemented.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to have a falls

prevention and management program to reduce the incidence of resident falls and the risk of injury and must be complied with.

Specifically, staff did not comply with the licensee's Neurological Vital Signs Post Head Injury following an unwitnessed fall. The policy directed to initiate head injury routine, if there was a possibility of a head injury, and to check the resident's pupil reaction. The Neurological Vital Signs Post Head Injury directed registered staff to complete every 15 min for the first hour, every hour for three hours, every four hours for the first 20 hours, then every eight hours to complete the remaining 48 hours to ensure the full 72 hours was covered by neurological assessment post HIR.

Rationale and Summary

A CI was submitted to the Director reporting that a resident had a fall that resulted in hospitalization and a significant change in the resident's condition.

The resident was calling out for help and the RN found the resident on the floor next to their bed. The RN assessed the resident for no injuries and the resident denied hitting their head. The RN documented the following morning that the resident was exhibiting symptoms. The resident was transferred to the hospital for assessment.

The RN and the Clinical Care Coordinator (CCC) confirmed the resident had an unwitnessed fall and the resident's neurological vital signs post head injury were not completed every 15 min for the first hour, every hour for three hours, and every four hours, as directed in the policy.

Failure to initiate a head injury routine when there was a possibility that the resident hit their head following an unwitnessed fall could have delayed the resident's need to be transferred to the hospital for assessment.

Sources: A resident's clinical health records, licensee's Falls Prevention and Management Program Policy, The Neurological Vital Signs Post Head Injury policy, and interviews with staff. [601]