Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Nov 04, 2014;	2014_349590_0015 (A1)	L-000699-14	Resident Quality Inspection

Licensee/Titulaire de permis

1230839 ONTARIO LIMITED
708 WELLINGTON STREET, WALLACEBURG, ON, N8A-2Y6

Long-Term Care Home/Foyer de soins de longue durée

BROUILLETTE MANOR
11900 BROUILLETTE COURT, TECUMSEH, ON, N8N-4X8

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

ALICIA MARLATT (590) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié
Please find the attached amended order with updated compliance date.

Issued on this 4 day of November 2014 (A1)

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

Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Inspection Report under the Long-Term Care Homes Act, 2007	**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée**

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
Nov 04, 2014;	2014_349590_0015 (A1)	L-000699-14	Resident Quality Inspection

Licensee/Titulaire de permis

1230839 ONTARIO LIMITED
708 WELLINGTON STREET, WALLACEBURG, ON, N8A-2Y6

Long-Term Care Home/Foyer de soins de longue durée

BROUILLETTE MANOR
11900 BROUILLETTE COURT, TECUMSEH, ON, N8N-4X8

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

ALICIA MARLATT (590) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 28, 29, 30, 31 & August 1, 5, 6, 7, 8, 2014.

The following Critical Incidents were inspected during the Resident Quality Inspection:

CI# 2301-000014-14 with log# L-002962-14

CI# 2301-000015-14 with log# L-002694-14

CI# 2301-000008-14 with log# L-000474-14

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Food Service and Nutrition Manager/Environmental Services Manager, the Resident Care Plan Coordinator, the Director of Activities and Restorative Care, two Cooks, a Registered Dietitian, eight Registered Nurses, three Registered Practical Nurses, eight Health Care Aides, six Personal Support Workers, five Environmental Service Workers, two Activity Aides, one Student, three Resident family members and 40+ Residents.

During the course of the inspection, the inspector(s) toured all resident home areas, observed dining services and the kitchen, medication rooms, medication administration, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and

reviewed resident clinical records, posting of required information, meeting minutes relevant to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident #0002 bed system was assessed and passed with a note that indicated the mattress did not fit the bed.
There was no assessment completed of the resident in the bed with the use of bed rails.
Progress notes indicate that Resident #0002 was found falling out of bed.

On July 31, 2014 The Administrator confirmed it is her expectation that all residents should have a two part assessment for bed system evaluations. The mattress was changed on July 31, 2014 before the Inspectors departure from the Home and the mattress corners were already in place. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used, the resident had been assessed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Review of Resident #22's plan of care revealed this resident uses bed rails for bed mobility, daily.
The inspector was unable to find documentation in the residents health care record to verify that Resident #22 had been assessed to minimize risk to this resident when bed rails were used.
The Director of Nursing confirmed Resident #22 uses bed rails and that this resident had not been assessed in relation to bed rail risks. [s. 15. (1) (a)]

3. The licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

On August 8, 2014 Residents #0016, # 0017 and #0018 were observed in their beds with the side rails in the up position. This was confirmed by the Resident Care Plan Coordinator.
These mattresses had been assessed and had passed inspection however the beds had not been assessed with the residents in the bed and with the use of side rails.
The Administrator and Director of Nursing confirmed the two part bed safety assessments had not been completed with the residents in their beds. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff were provided training in skin and wound care.

The Director of Nursing and the Administrator confirmed that direct care staff have not received training in skin and wound care in 2013 or 2014. [s. 221. (1) 2.]

2. The licensee has failed to ensure that all direct care staff were provided training in continence care and bowel management.

The Director of Nursing and the Administrator confirmed that direct care staff have not received training in continence care and bowel management in 2013. [s. 221. (1) 3.]

3. The licensee has failed to ensure that training has been provided for all staff who apply physical devices or who monitor residents restrained by a physical device which includes application of these physical devices, use of these physical devices and potential dangers of these physical devices.

During the annual training in 2013 and the first 7 months of 2014, 7 out of 60 staff members completed training in the use, application and potential dangers of restraint by physical devices.

The Director of Nursing and the Administrator confirmed that only 7 out of 60 direct care staff members have received training in restraining by physical device since January 2013. [s. 221. (1) 5.]

4. The licensee has failed to ensure that all staff who apply PASDs or who monitor residents with PASDs including the application of PASDs, use of these PASDs and potential dangers of these PASDs have been provided training in these areas.

The Administrator and Director of Nursing confirmed the home has not provided training to any staff who apply PASDs or who monitor residents with PASDs including the application of PASDs, the use of PASDs and potential dangers of PASDs in 2013 and thus far in 2014. [s. 221. (1) 6.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 all direct care staff are provided annual training in skin and wound care and continence care and bowel management, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The care plan for Resident #41 indicated that the bed side rails are to be left down and not used.
On July 31, 2014 Inspector #590 observed the side rails up.
The Administrator and Director of Nursing confirmed that side rails are to be left down and not to be used for Resident #41. [s. 6. (7)]

2. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On July 28, 2014, Resident #22 was observed at the lunch meal service.
Review of Resident #22's dietary plan of care card posted in the kitchen binder listed this resident's diet texture as minced. The dietary plan of care posted in the kitchen binder listed a recommendation regarding food texture. An Environmental/Food Service Staff Member confirmed the texture was a preference rather than a safety issue for this resident.
This same Environmental/Food Service staff member asked Resident #22 if their meal was the right texture for them and resident stated "it would have been nice to have minced food".
The Food Service and Nutrition Manager confirmed Resident #22's plan of care stated to provide a minced texture and that this resident's sandwich should have been prepared accordingly prior to serving. [s. 6. (7)]

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 the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Resident #0002 has two areas of altered in skin integrity.
There is no documentation of these alterations of skin integrity in the plan of care and no indication that these injuries were reported to the RN.
The Skin and Wound care Policy last reviewed June 2014 states that Personal Support Worker's and Health Care Aide's will report/document any skin concerns or changes to the registered staff.
The Director of Nursing confirms it is her expectation that the homes policies be complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure strategy or system put in place by the licensee was complied with.

The homes policy for "Minimizing Restraining of Residents and the Use of Personal Assistance Service Devices (PASDs)" page 12 of 13, item #6, under the section titled "The Assessment will:", states:
"Obtain and record informed consent (including that the risks and benefits of alternative treatment options and that the risks and benefits related to use of the PASD have been outlined to the resident/SDM (Health Care Consent Act, 1996))."
Review of Resident #22's plan of care revealed this resident uses an identified PASD daily. This was also verified by the Director of Nursing.
The inspector was unable to locate a record of informed consent in relation to the use of this PASD for Resident #22. The Director of Nursing confirmed informed consent of this PASD had not yet been recorded. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee had failed to ensure that any plan, policy, procedure, strategy or system put in place was complied with.

The homes policy and procedure with the subject title "Food Service Temperatures" states:
"Designated dietary staff take food temperatures in the center of the thickest part of the food when cooking, chilling, hot holding or reheating, and immediately prior to serving." and
"Temperatures are recorded on the Food Temperature Recording Sheet. Any discrepancies with established criteria are noted and corrective action taken".
Food Temperature Recording Sheets were reviewed and the following was revealed:
July 31, 2014 - the only temperatures recorded were for point of service, for all meals.
July 30, 2014 - temperatures for breakfast were recorded for reheat/cooked temperature only and temperatures for point of service were recorded for lunch and supper only.
July 18, 2014 - the only temperatures recorded were for point of service, for all meals.
The Food Service and Nutrition Manager confirmed the homes policy and procedure for Food Service Temperatures was not complied with. [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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the continence care and bowel management program had assessment and reassessment instruments that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

During the RQI, Residents #22 and #43 were noted to have incontinence. The inspectors were unable to locate assessments and/or re-assessments which included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.
The Administrator and Director of Nursing confirmed the home did not have assessment and reassessment instruments for continence care and bowel management. [s. 48. (2) (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 the continence care and bowel management program had assessment and reassessment instruments that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

During stage one of this RQI Resident #0002 was noted to have a 2.5cm x 1 cm wound.
There was no notation in the progress notes, no skin assessment completed, no documentation in the Treatment Administration Records and no documentation on the 24 hour reports going back for the last 3 weeks.

The Director of Nursing confirmed that it is the homes expectation that all wounds are reported to the Registered Nurse and that these wounds are assessed and documented. [s. 50. (2) (b) (i)]

2. The licensee had failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Review of Resident #23's health record revealed this resident sustained a skin tear which was documented as healed two weeks later. Treatment for this skin tear included applying a dressing to the area. The inspector was unable to locate a clinically appropriate skin assessment for this wound.
The Director of Nursing and Administrator confirmed Resident #23's skin tear was not assessed using the homes clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

a) The latest care plan, MDS assessment and 2 staff members have confirmed that resident #43 is incontinent.
b) Inspector #590 was unable to locate an incontinence assessment for Resident #43.
c) The Director of Nursing confirmed that there has been no incontinence assessment completed for resident #43. [s. 51. (2) (a)]

2. The licensee has failed to ensure that each resident who is incontinent received an assessment that includes identification of causal factors, patterns, and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Review of Resident #22's health record revealed the resident had total bowel continence, at the time of their annual assessment. Resident #22's quarterly assessment documentation, indicated this resident was usually continent for bowels. The Director of Nursing and Administrator confirmed Resident #22 had not received an assessment that included identification of causal factors, patterns, and potential to restore function with specific interventions for bowel incontinence. [s. 51. (2) (a)]

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 the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that all menu items were prepared according to the planned menu.

On July 28, 2014, inspector #516 completed a dining observation of the lunch service. The menu included peaches or lemon mousse for dessert.
The inspector observed that the peaches and lemon mousse were pre-poured into dessert dishes and were sitting on trays, on the kitchen counter beside the hot table at 12:00. At, 12:45, both desserts were being served to the residents. The cook confirmed both the peaches and the lemon mousse options had been sitting outside of the fridge on trays beside the hot table since at least 12:00. The inspector requested that the temperature of the desserts be taken at serving time.
The Food Temperature Recording Sheet states the minimum temperature for cold foods was 4 degrees Celsius or lower. Further, the procedure listed on the homes standardized recipes stated the lemon mousse and the peaches were to be kept chilled at 4 degrees Celsius for service.
The Cook and Food Service and Nutrition Manager, both confirmed the temperature of the desserts as; the lemon mousse was 25 degrees Celsius and the peaches were 23.4 degrees Celsius and the Food Service and Nutrition Manager also confirmed the menu items were not prepared according to the standardized recipe regarding keeping the items chilled for service. [s. 72. (2) (d)]

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 all menu items were prepared according to the planned menu, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and the Regulations.

The Inspector requested to view the licensee's staff training records for 2013 for minimizing of restraints and how to restrain residents in accordance with the Act and Regulations. The Administrator and Director of Nursing both confirmed that the licensee did not provide training in 2013 and thus far in 2014, to all staff who provide direct care to the residents, as a condition of continuing to have contact with residents, on how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and the regulations. [s. 76. (7) 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 that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and the Regulations, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure there is an analysis of the restraining of residents by use of a physical device undertaken on a monthly basis.

The Director of Nursing and the Administrator confirm there have been no monthly analysis of the restraining of residents by use of a physical device. [s. 113. (a)]

2. The licensee failed to ensure that a written record of the annual evaluation and the changes and improvements required, the names of the persons who participated in the evaluation; and the date that the changes were implemented.

The Director of Nursing and the Administrator confirmed that there is no written record of the annual evaluation, any changes or improvements to the program, any persons who participated in the evaluation or the dates any changes were made. [s. 113. (e)]

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 ensure that a written record of the monthly analysis, the annual evaluation and the changes and improvements required, the names of the persons who participated in the evaluation; and the date that the changes were implemented, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that retraining for staff in infection prevention and control includes, (a) hand hygiene; (b) modes of infection transmission; (c) cleaning and disinfection practices; and (d) use of personal protective equipment.

The Administrator and Director of Nursing confirmed that staff retraining in:
(a) hand hygiene; (b) modes of infection transmission; (c) cleaning and disinfection practices; and (d) use of personal protective equipment was not completed in 2013. [s. 219. (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 that retraining for staff in infection prevention and control includes, (a) hand hygiene; (b) modes of infection transmission; (c) cleaning and disinfection practices; and (d) use of personal protective equipment, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to inform the Director no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Resident #0015 sustained an injury that resulted in a significant change in health condition and for which the resident was taken to hospital.
The Administrator confirmed that a Critical Incident report was not submitted within 24 hours of the incident.
The Administrator confirmed it is the homes policy to submit a Critical Incident within 24 hours of the incident. [s. 107. (3) 4.]

Issued on this 4 day of November 2014 (A1)

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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : ALICIA MARLATT (590) - (A1)

Inspection No. / No de l'inspection : 2014_349590_0015 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : L-000699-14 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Nov 04, 2014;(A1)

Licensee / Titulaire de permis : 1230839 ONTARIO LIMITED
708 WELLINGTON STREET, WALLACEBURG, ON, N8A-2Y6

LTC Home / Foyer de SLD : BROUILLETTE MANOR
11900 BROUILLETTE COURT, TECUMSEH, ON, N8N-4X8

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l’administratrice ou de l’administrateur : NANCY COMISKEY

To 1230839 ONTARIO LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

(A1)
The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79 10, s.15.1 (a) that includes:

1. An immediate assessment of all residents who use bed rails to determine if their bed system is appropriate for their needs.
2. The immediate correction of any bed systems already evaluated which require modifications.
3. What interventions will be implemented to mitigate risks to the residents that use one or more bed rails for beds that failed any zone of entrapment. This includes all beds, whether the mattress is foam based or not.
4. The plan must include dates of when the assessments will be completed and when care plans will be updated.
5. Identify what long term measures will be implemented to ensure beds continue to pass all zones of entrapment and the time lines.
6. Summarize how and when staff have been or will be trained and oriented with respect to bed safety.

Please submit the plan in writing, to Alicia Marlatt Long-Term Care Homes Inspector, Ministry of Health and Long Term Care Performance Improvement and Compliance Branch 130 Dufferin Avenue 4th Floor London Ontario N6A 5R2, by email alicia.marlatt@ontario.ca by September 22, 2014.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident #0002 bed system was assessed and passed with a note that indicated the mattress did not fit the bed.
There was no assessment completed of the resident in the bed with the use of bed rails.
Progress notes indicate that Resident #0002 was found falling out of bed.

On July 31, 2014 The Administrator confirmed it is her expectation that all residents should have a two part assessment for bed system evaluations. The mattress was changed on July 31, 2014 before the Inspectors departure from the Home and the

mattress corners were already in place. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used, the resident had been assessed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Review of Resident #22's plan of care revealed this resident uses bed rails for bed mobility, daily.
The inspector was unable to find documentation in the residents health care record to verify that Resident #22 had been assessed to minimize risk to this resident when bed rails were used.
The Director of Nursing confirmed Resident #22 uses bed rails and that this resident had not been assessed in relation to bed rail risks. [s. 15. (1) (a)]

3. The licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

On August 8, 2014 Residents #0016, # 0017 and #0018 were observed in their beds with the side rails in the up position. This was confirmed by the Resident Care Plan Coordinator.
These mattresses had been assessed and had passed inspection however the beds had not been assessed with the residents in the bed and with the use of side rails.
The Administrator and Director of Nursing confirmed the two part bed safety assessments had not been completed with the residents in their beds. [s. 15. (1) (a)]
(518)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Dec 03, 2014(A1)

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, r. 221. (1) 5 and 6 regarding training for staff who apply physical devices and PASDs that includes:

1. The dates the training will be completed for all staff members.
2. What long term measures will be implemented to ensure timely re-training of all direct care staff.

Please submit the plan in writing, to Alicia Marlatt Long-Term Care Homes Inspector, Ministry of Health and Long Term Care Performance Improvement and Compliance Branch 130 Dufferin Avenue 4th Floor London Ontario N6A 5R2, by email alicia.marlatt@ontario.ca by September 26, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that training has been provided for all staff who apply physical devices or who monitor residents restrained by a physical device which includes application of these physical devices, use of these physical devices and potential dangers of these physical devices.

During the annual training in 2013 and the first 7 months of 2014 7 out of 60 staff members completed training in the use, application and potential dangers of restraint by physical devices.

The Director of Care and the Administrator confirm that only 7 out of 60 direct care staff members have received training in restrain by physical device since January 2013.
(518)

2. The licensee has failed to ensure that all staff who apply PASDs or who monitor residents with PASDs including the application of PASDs, use of these PASDs and potential dangers of these PASDs have been provided training in these areas.

The Administrator and Director of Care confirmed the home has not provided training to any staff who apply PASDs or who monitor residents with PASDs including the application of PASDs, the use of PASDs and potential dangers of PASDs in 2013 and thus far in 2014. (516)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Dec 18, 2014

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4 day of November 2014 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : ALICIA MARLATT - (A1)

Service Area Office / Bureau régional de services : London