Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 19, 2016	2016_257518_0027	017028-16	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

ALISON FALKINGHAM (518), CAROLEE MILLINER (144), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 13, 14, 15, 16, 17, 21 and 22, 2016

During this Resident Quality Inspection the Inspectors also reviewed:
Log #003203-16 CIS 2301-000002-16 related to staff to resident abuse
Log #013101-16 CIS 2301-000004-16 related to staff to resident abuse
Log #017940-16 CIS 2301-000006-16 related to a resident fall with transfer to the hospital
Log #018079-16 CIS 2301-000003-16 related to a resident fall with transfer to the hospital

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), the Assistant Office Manager, four Registered Nurses (RN), three Registered Practical Nurses(RPN), eight Personal Support Workers (PSW), two Health Care Aides(HCA), the Food Service Manager, the Maintenance Supervisor, the Activation Manager, one Housekeeper, the Physiotherapist, a Physiotherapy Assistant and one Restorative Aide.
The Inspectors also toured the facility, observed one meal service, one medication administration pass and general staff to resident interactions and reviewed forty resident clinical records and the home's policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 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	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 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).

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 had failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A resident's plan of care included the use of medical devices.
A note posted on the wall over the resident's bed provided direction to staff for the use of the device.

The resident was observed during the Resident Quality Inspection with the medical devices not in use.

Two staff members advised the Inspector that the medical device was to be in one position during residents care, one staff member stated the device was only to be used when the resident was in bed and two staff members stated that the device should not be used.

The DOC and a staff member stated that the resident required the medical devices to be in place when the resident was in bed.

The DOC agreed the resident's plan of care regarding the medical device was confusing for staff and had not provided clear directions. [s. 6. (1) (c)]

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.

The plan of care for a resident provided direction to staff regarding the use of a medical device.

The resident was observed in their bed without the medical device in place.

Five staff members gave conflicting responses to the Inspector related to the use of the medical device.

The DOC and a staff member stated the resident required the medical device and that the plan of care was not followed.[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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee had failed to ensure that the PASD described in subsection (1) that is used to assist a resident with a routine activity of living was included in the residents' plan of care.

A resident was observed using a medical device on two occasions in two areas of the home.

The DOC and two staff member stated the resident used the medical device for routine activities of daily living and that the device was not monitored or documented on.

The home's Minimizing Restraining of Residents and the Use of Personal Assistance Services Devices, Section 1 of the Nursing Administration Manual, last revised December 2011 included the following requirements:
- informed consent from the resident and or SDM
- approval by a physician, RN, RPN, OT or PT
- policy for Use of Restraints must be followed

- consider and try alternatives to the use of a PASD
- develop goals and strategies on the care plan in collaboration with the team
- monitor the PASD according to the care plan.

Review of the resident's clinical record revealed that the medical device was being used as a PASD, was not included in the resident's plan of care, that there was no consent from the resident or SDM, the PASD had not been approved by a physician, RN, RPN, OT or PT, alternatives to the use of a PASD had not been completed, and that the tilt function when in use was not monitored according to the plan of care.

The DOC said the medical device was considered a PASD and that nursing staff should have included it in the resident's plan of care. [s. 33. (3)]

2. The licensee has failed to ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of daily living only if the use of the PASD is included in the residents plan of care.

A resident was observed on two occasions with a medical device in use.

Three staff members explained that the resident used the medical device as a PASD for comfort measures.

The home's Minimizing Restraining of Residents and the Use of Personal Assistance Services Devices, Section 1 of the Nursing Administration Manual, last revised December 2011 includes the following requirements:
- informed consent from the resident and or SDM
- consider and try alternatives to the use of a PASD
- monitor according to the care plan.

Review of the clinical record for the resident does not include the use of the medical device, informed consent from the resident and or SDM, an alternatives assessment to the use of a PASD and monitoring of the PASD when in use.

One staff member said that the PASD when in use was not monitored as it wasn't a restraint, one staff member said that an alternatives assessment to the use of the PASD had not been completed and two staff members told the Inspector informed consent from the resident and or SDM had not been obtained.

The DOC told the Inspector that the use of the medical device as a PASD should have been included in the plan of care. [s. 33. (3)]

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 use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 3. The use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. 4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 5. The plan of care provides for everything required under subsection (5)., to be implemented voluntarily.

WN #3: 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 had failed to ensure that the Director was informed of the following incident in the home no later than one business day after an injury in respect of which a person was taken to hospital.

Review of a resident's clinical record revealed that the resident had an incident in their room, was assessed for injuries and returned to bed.
Later the same day the resident was found to be uncomfortable, was reassessed and transferred to the hospital.

Review of the critical incident report submitted to the Ministry of Health and Long Term Care revealed that the report was submitted eight days after the incident.

The DOC stated that this critical incident was submitted eight days after the incident and confirmed that the expectation was that a critical incident should be submitted within one business day after a resident was injured and taken to the hospital. [s. 107. (3) 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 the Director is informed of the following incidents in the home no later than one business day after the of the incident, followed by the report required under subsection (4):
4. An injury with respect of which a person is taken to the hospital, to be implemented voluntarily.

Issued on this 19th day of July, 2016

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

Original report signed by the inspector.