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

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Original Public Report

Report Issue Date: October 18, 2022	
Inspection Number: 2022-1062-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: 1230839 Ontario Limited	
Long Term Care Home and City: Brouillette Manor, Tecumseh	
Lead Inspector Cassandra Taylor (725)	**Inspector Digital Signature** Cassandra L Taylor 2022.10.18 10:37:43 -04'00'
Additional Inspector(s) Debra Churcher (670)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 4-7, 11-12, 2022

The following intake(s) were inspected:

- Intake: #00005510-Proactive Compliance Inspection

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

Infection Prevention and Control
Medication Management
Resident Care and Support Services
Prevention of Abuse and Neglect
Residents' Rights and Choices
Food, Nutrition and Hydration

Residents' and Family Councils
Quality Improvement
Pain Management
Skin and Wound Prevention and Management
Falls Prevention and Management
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes 10.1 states: The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% ABHR.

The Provincial Infectious Diseases Advisory Committee (PIDAC) document titled, "Best Practices for Hand Hygiene in All Health Care Settings" 4th edition stated, "For maximum compliance and use, health care providers should perform hand hygiene at the appropriate moment of care. ABHR should be located at point of care, i.e., the place where three elements come together, the client/patient/resident, the health care provider and care or treatment involving the client/patient/resident contact. Point-of-care products should be accessible without leaving the client/patient/resident."

Rational and Summary
During the initial tour of the home, showed four wall mounted ABHR throughout a specific resident hallway and no ABHR available in the resident rooms at point of care.

During an interview with Personal Support Worker (PSW) they stated there had been instances when they had not been able to complete hand hygiene between residents when performing care due to the

limited availability of ABHR in the specific resident hallway.

Sources: Infection Prevention and Control Standard for Long-Term Care Homes, Provincial Infectious Diseases Advisory Committee document, observation of the specific resident hallway and interview with PSW.

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WRITTEN NOTIFICATION: Care Plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rational and Summary
During a dining observation, a resident was observed in the dining room at a table. The resident was served their soup and then an entrée. The resident was not served any beverages. The resident was later removed from the dining room. No beverages were offered or attempted to be given during the lunch observation.

Review of the home's policy titled: Meal Service, effective date August 2014; indicates, "2. Residents are provided choice of food and beverage based on the posted and communicated menu and in a manner suitable to each resident's ability. The resident’s method of choice is clearly stated on the plan of care and the dining kardex. Individual residents' preferences for the way in which meals are normally eaten is followed and documented in the dining kardex. 3. Serving staff refer to the dining kardex and the list of the residents' like and dislikes for the residents who are unable to make or communicate a choice. This is clearly stated on the resident's dining kardex for future meals."

Review of the resident's care plan indicated the resident was identified as a high nutritional risk and had goals to maintain a daily fluid intake of a specific amount. Review of the Health Care Aide Flow Sheet; Intake: Fluid record, indicated the lunch fluids were refused, however none were offered during the lunch dining service.

During an interview with the Food and Nutrition Services Manager (FNSM), they indicated that the

resident should have at least been offered a beverage prior to their meals being served.

Sources: Resident records, Dining observation, the home's policy and staff interview with the FNSM.

[725]

WRITTEN NOTIFICATION: Doors in the Home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 12 (1) 1. i.

The licensee failed to ensure that the following rules were complied with: All doors leading to the outside of the home must be, kept closed and locked.

Rational and Summary
During a tour of the home, the emergency exit door at the end of a specific hallway of the home was found to be unlocked.

The Maintenance Supervisor (MS) stated that they complete a check of all doors every morning and on or around September 26, 2022, they found that emergency exit door to the specific hallway of the home was unlocked and there was no power to the magnetic lock. MS stated that they called for repair as soon as they identified the issue however, there was a delay due to waiting for parts. MS stated that staff were monitoring the exit “as best as they could” and acknowledged that the unlocked door was not monitored at all times.

During an interview with the Infection Prevention and Control Lead Environmental Supervisor (IPACES) they shared that the area outside of the emergency exit for the specific hallway of the home, while connected to the courtyard, had temporary fencing around it due to construction it was not considered a secured area at this time and residents would not be allowed in that area unsupervised.

Sources: Observation and interviews with MS and IPACES.

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WRITTEN NOTIFICATION: Training and Orientation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 261 (1) 2.

The licensee failed to ensure that all direct care staff received their mandatory annual training on the required program of Skin and Wound Care.

Rational and Summary
Inspector requested the education documents for the required programs from the Director of Nursing (DON). DON returned with documentation of mouth and foot care education and indicated that there was an issue with the online learning module where the mandatory education of Skin and Wound Care dropped off the course requirements. DON indicated that the Skin and Wound Care education has been added back to the course requirements but as a result all direct care staff did not complete the mandatory annual Skin and Wound Care education for 2021.

Sources: Interview with DON.

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WRITTEN NOTIFICATION: General Requirements for Programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 34 (1) 1.

A) The licensee failed to ensure there was a written description of the Pain Management Program that included its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Rational and Summary
During a record review, the program description for the home's Pain Management Program was requested. A copy of an Admission – Pain Management Policy was provided. Review of the home's policy titled: Admission- Pain Management Policy; effective: February 2002, revised; October 2012; was reviewed and was not a written description of the Pain Management Program.

During an interview with the DON, it was confirmed that the home had no other written policies or program description for the Pain Management program.

Sources: Staff interview with the DON.

B) The licensee failed to ensure that the written Falls Prevention and Management Program description included relevant policies, procedures and protocols and included protocols for the referral of residents to specialized resources where required.

Rational and Summary
A record review was completed of the home's written description of the Falls Prevention Program, effective date, December 2011. During an interview with RPN, Resident Assessment Instrument / Minimum Data Set (RAI/MDS) Coordinator and the program lead DON, all indicated the process and protocols required for assessments and referrals for the falls prevention program. Through the interviews it was indicated that there were a number of assessments available where required and a process for referrals for specialized resources where required, that was not indicated within the homes policies and procedures.

During an interview with the DON, they indicated that the written description and the policies and procedures are missing required information.

Sources: The home’s written Falls Prevention Program and staff interviews with RPN, RAI/MDS Coordinator and the DON.

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WRITTEN NOTIFICATION: General Requirements for Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 34 (1) 3.

The licensee failed to complete an annual program evaluation of the Pain Management, Falls Prevention and Management and Skin and Wound Care Programs.

Rational and Summary
A) During an interview with the DON, they indicated that they did not complete an annual evaluation of the 2020, Pain Management Program in 2021.

B) During an interview with the DON, they indicated that they did not complete an annual evaluation of the 2020, Falls Prevention and Management Program in 2021.

C) During an interview with the DON, they indicated that they did not complete an annual evaluation of the 2020 Skin and Wound Care Program in 2021.

Sources: Staff interview with the DON.
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WRITTEN NOTIFICATION: Nutritional Care and Hydration Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (1) 5.

The licensee failed to ensure that food was served at a temperature that was safe to the residents.

Rational and Summary
During a record review of the Food Temperature Recording Sheet on a specific date, it was noted that one of the main entrée choices did not have a temperature recorded. The barbequed sausage did not have a cooked temperature or a temperature at the time of service.

During an interview with the Cook, they indicated that temperatures were taken however, were not recorded. An interview with the FNSM, indicated it would be the expectation that temperatures are taken when cooked and again prior to service.

Policy titled Food Service Temperatures effective March 1, 2009, indicated; " The temperature of all food will be monitored at each meal and corrective action taken, when necessary, in servery, this is to ensure that all food items are safe for consumption and to prevent the growth of and/or production of pathogens in potentially hazardous foods."

Sources: Food Temperature Recording Sheet, the home's policy and Staff interview with Cook and FNSM.

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WRITTEN NOTIFICATION: Nutritional Care and Hydration Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (1) 9.

Rational and Summary
The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance.

During a lunch dining observation on a specific date, three residents were noted to be in a tilt position while eating or being assisted to eat. Registered Practical Nurse (RPN) indicated that the safe position for residents when eating was upright unless otherwise care planned.

During a breakfast observation on a specific date, six residents were noted to be in a tilt position while eating or being assisted to eat. Inspector asked the DON to attend the dining room and note the residents in the tilt position. The FNSM indicated the identified residents did not have tilt care planned for meals.

Review of the home's policy titled; General Feeding Guidelines in the Dining Room, effective March 2009, indicated; "Residents are properly position in an upright position and able to tilt their head slightly forward to facilitate safe swallowing and help prevent food from entering their airway. Any variations or adjustments to achieve this positioning needs to be clearly indicated on the care plan."

Sources: Observations, staff interviews with RPN and FNSM and the home's policy.

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