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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: August 23, 2023

Inspection Number: 2023-1062-0004

Inspection Type:
Complaint
Critical Incident System

Licensee: 1230839 Ontario Limited

Long Term Care Home and City: Brouillette Manor, Tecumseh

Lead Inspector	**Inspector Digital Signature**
Cassandra Taylor (725)	Cassandra L Taylor Digitally signed by Cassandra L Taylor Date: 2023.08.29 11:30:55 -04'00'

Additional Inspector(s)
Julie DAlessandro (739)
Terri Daly (115)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14 -18, and 21, 2023
The inspection occurred offsite on the following date(s): August 22, 2023

The following intake(s) were inspected:

- Intake: #00090614 - Complaint intake - relating to hot weather temperatures, nursing and personal support services and housekeeping.
- Intake: #00091726 - Complaint intake - relating to staffing concerns.
- Intake: #00092008 - Complaint intake - relating to staffing concerns, nursing and personal support services, menu planning and plan of care.
- Intake: #00090649 - Critical Incident (CI) # 2301-000008-23 relating to medication administration.
- Intake: #00091447 - CI # 2301-000010-23 relating to falls prevention and management.

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

Continence Care
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bathing

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee failed to ensure that residents received at a minimum two baths per week by a method of their choice.

Several residents were not provided with a minimum of two baths per week during the review period.

Review of the Personal Support Worker (PSW) staff schedule for the review period indicated, the home was not working with a full staffing compliment on the day shift 11 out of 14 days and on the evening shift 12 out of the 14 days.

Review of the home's staffing plan, did not provide for clear direction on how to complete residents baths when missed.

The Director of Nursing (DON) confirmed that bathing was not provided to the residents who were reviewed at a minimum of two baths per week.

Sources: Resident records, PSW staff schedule, the home's staffing plan and interview with the DON.

[725]

WRITTEN NOTIFICATION: Menu Planning

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (b)

The licensee failed to ensure the menu for a specific snack cart included items for texture modified diets.

An observation was completed for a specific snack cart, and the snack menu did not provide choices for a specific texture modified diet.

The DON confirmed the items available on the specific snack cart did not include choices for a specific texture modified diet.

Sources: Observations and staff interviews with DON.

[725]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.

The licensee failed to communicate the seven-day and daily snack menus to residents.

During observations in the home the seven-day and daily snack menus were not posted for residents to view.

The DON confirmed the snack menus were not posted.

Sources: Observations and staff interview with DON.

[725]

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee failed to ensure that that no drug was administered to a resident unless the drug had been prescribed for them.

A resident was administered a drug that was not prescribed to them.

During an interview with the DON they acknowledged that the resident received medication that was not prescribed for them.

Sources: Resident's progress note and interview with the DON.

[739]

WRITTEN NOTIFICATION: Resident records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

The licensee failed to ensure that resident's fluid intake records were kept up to date at all times.

Review of six resident fluid intake records had shown multiple missing entries.

The DON confirmed that the documentation was missing or incomplete and should have been completed.

Sources: Resident records and interview with DON.

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