Ontario

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

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

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Original Public Report

Report Issue Date: November 28, 2023	
Inspection Number: 2023-1062-0005	
Inspection Type: Complaint Critical Incident	
Licensee: 1230839 Ontario Limited	
Long Term Care Home and City: Brouillette Manor, Tecumseh	
Lead Inspector Jennifer Bertolin (740915)	**Inspector Digital Signature** Jennifer Bertolin Digitally signed by Jennifer Bertolin Date: 2023.12.13 08:57:41 -05'00'
Additional Inspector(s) Julie D'Alessandro (739)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 23, 25-27, 30, 31, 2023 and November 1- 3, 2023

The following intake(s) were inspected:
• Intake: #00095014 [CI: IL-16608-AH/2301-000013-23]-Related to resident care and support services.
• Intake: #00095722- Complainant related to resident care and support services, fall prevention & management, medication management, and skin & wound prevention and management.
• Intake: #00096851- Complaint related to falls prevention and management.

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
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

Introduction
The licensee failed to review and reassess the effectiveness of a resident's fall prevention interventions and strategies, after falls they had on specific dates.

Rationale and Summary
Review of a resident's progress notes in point click care (PCC) indicated that they had falls on specific dates.

Review of a resident's care plan (CP), that fall prevention interventions and strategies were listed that were initiated upon admission noted there were no revisions or updates to care plan completed after these falls from specific dates.

Review of a resident's CP, that indicated on a specific date, a new fall prevention intervention and strategy was implemented that included using an assistive device to help with positioning and preventing falls.

During an interview with a staff member, the expectation of registered staff is to reassess effectiveness of fall interventions post falls, and if interventions are deemed ineffective, to implement, revise, and update plan of care describing the new interventions/strategies to minimize falls and reoccurrence. The staff member acknowledged that a resident fall interventions were not reassessed after these particular dates, and no new interventions or strategies were implemented at that time.

The home failed to reassess and revise the effectiveness of a resident's plan of care regarding fall interventions and increased the risk for potential complications and the ability to reduce recurrence in order to maintain health and well-being

Sources: Progress Notes, Care Plans, and Staff Interviews
[740915]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Introduction

The licensee failed to protect a resident from neglect by staff.
For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

Review of a resident's progress notes in PCC indicated they had falls on specific dates.

Review of a resident's Falls-Post Fall Assessments documentation in PCC for dates mentioned, noted in section F, Huddle Notes, that there were no new strategies and interventions recommended to minimize the risk or reoccurrence of falls.

Review of resident's CP specific to fall interventions, documented that there were no new fall interventions implemented to minimize the risk or prevent the reoccurrence of falls until a specific date.

During an interview with a staff member, acknowledged that new fall interventions or strategies were not implemented after the falls that occurred during a three-month span.

On a specific date, it was documented in a resident's progress notes that they had complaints of pain post fall. During an interview with a staff member, they stated they did not give the resident a Pro Re Nata (PRN) pain medication on this date as they did not think the resident was in pain.

A separate progress note on a specific date, indicated that a resident was complaining of pain, and a PRN pain medication was administered but was documented as ineffective and no further assessment was completed.

A progress note documented on a specific date, indicated that after meeting with the resident's power of attorney (POA), there were medication changes to the resident's pain management.

A progress note documented on a specific date, indicated that the resident showed discomfort during personal care.

A progress note documented on a specific date, indicated during night shift that the resident,

expressed pain during personal care.

A review of a resident's Electronic Medication Administration Record (EMAR) for a certain month was completed and noted that they had an order for PRN pain, however the pain medication was not administrated on specific dates when the resident was experiencing and expressing pain.

A review of a resident's CP for pain monitoring had an intervention of administering pain medications as ordered. During an interview with a staff member, they stated that the expectation would have been for registered staff to have utilized PRN pain medications as prescribed.

Review of a staff member's documentation for a specific date, in PCC indicated that staff informed a registered staff member that the resident was exhibiting behaviours and had skin and wound concerns. Upon assessment the registered staff member documented that the resident's had altered skin integrity.

A review of another registered staff member's documentation noted on a specific date, also indicated that the resident was exhibiting actions that indicated behaviours and altered skin integrity.

Review of the Brouillette Manor North Hall Physician Nurse Practitioner (NP) sheet documented that the resident had a fall on a certain date. There was no notation on the Physician NP sheet that the resident had another fall on a different date, or that the resident had unresolved pain after receiving PRN pain medication.

A separate progress notes by a registered staff member on a specific date, indicated that staff had been reporting for a short duration of time that the resident had increased pain during movement and transfer.

The resident had complaints of pain, a staff member documented that the resident had altered skin integrity and the resident had limited movement of extremities. According to staff member's documentation a diagnostic test was ordered.

A record review of the prescriber order form for a specific date, indicated that a telephone order was obtained from the physician for a diagnostic test due to severe pain related to falls.

Review of skin and wound assessments for the resident in PCC and hard copy chart indicated

there were no documentation to show that registered staff had assessed and monitored the altered skin integrity in these specific areas.

On specific dates within a certain month, it was documented in the progress notes that the resident was exhibiting responsive behaviours with staff. During an interview with a staff member and management, both indicated that responsive behaviours are pain indicators.

During an interview with management, stated if a resident had experienced increased pain or responsive behaviours after a fall, the expectation would be that registered staff monitor, assess, and call the physician or NP for a diagnostic tests to rule out injuries.

The home's consistent inaction for the resident regarding fall risk, pain management, monitoring of altered skin integrity, and timely follow-ups based on staff assessments had potential to compromise the resident's health and well-being.

Sources: Progress Notes, Care Plan, EMAR, Doctor & NP Round Sheets, and Staff Interviews [740915]

WRITTEN NOTIFICATION: Skin and Wound Care
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Introduction
The licensee failed to ensure that two resident's, who were exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
A) Progress notes for a resident in PCC indicated that on certain dates within a one month time period, that the resident had sustained multiple altered skin integrity's to specific areas. There were no skin and wound assessments or weekly skin assessments completed for these in either PCC or on a hard copy assessment tool.

During an interview with a staff member, they were unable to find a completed skin and wound assessment tool documentation for these specific areas of altered skin integrity. The staff member acknowledges that a clinical assessment tool for skin and wound should have been completed on the resident's altered skin integrity.

Management indicated that the expectation would be that registered staff would complete a skin assessment using a clinically appropriate skin and wound assessment tool for these specific areas of altered skin integrity. Management acknowledged that skin and wound assessments were not completed on the resident's altered skin integrity.

When the home did not complete weekly assessments of the resident's to monitor impaired skin integrity, the risk of complications may not have been identified and treatment initiated immediately.
[740915]

Rationale and Summary
B) It was documented in a resident's progress notes in Point Click Care (PCC) that on a specific date, they had a fall and there were no injuries noted at that time. On a later date, a staff member wrote a progress note indicating that the resident had altered skin integrity to a specific area on their body. A second note in PCC, indicated that another staff member had noticed the same altered skin integrity on the resident.

During separate interviews with two staff members, they both indicated that the altered skin integrity that a resident had was considered the Ministry of Long-Term Care's (MLTC's) definition of altered skin integrity. Both staff members stated that they had documented the altered skin integrity in the progress notes but an assessment using a clinically appropriate assessment instrument had not been completed.

During an interview with management, they stated that the resident's altered skin integrity was considered the MLTC's definition of altered skin integrity and that the staff were to have documented the assessment of the resident's altered skin integrity on a skin and wound record located in a binder on the unit. Inspector and management went to view the record on the unit, and it was not there.

Management acknowledged that a skin assessment for the resident altered skin integrity had not been completed, using a clinically appropriate assessment instrument, by a member of the registered staff.
[739]

Sources: Residents progress notes, Interview with staff members and management, Skin and Wound Assessments

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 (2)

Introduction
The licensee failed to ensure that medications were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
Review of the resident electronic medication administration record (EMAR) for a specific month indicates that a resident had as needed (PRN) -medical directive (MD) order- for pain.

Noted in the resident's progress notes that on a specific date resident had a fall without injury, and had complaints pain post fall. Review of the resident's EMARS, noted that the PRN pain medication was not given.

During an interview with a staff member, they stated they did not give the resident PRN pain medication on this specific date as they did not think the resident was in pain.

It was documented in the resident's progress notes that there were medication changes regarding pain management on a specific date. Medication changes consisted of a PRN that is substantially stronger in strength.

On certain dates, resident had complaints of pain, and reviewed resident's EMARS and noted that the stronger PRN pain medication was not given.

During an interview with management, the expectation would be that staff would utilize PRN pain medication when a resident expressed they have pain. Management acknowledged that PRNs were not given to the resident when they expressed they had pain.

When the home failed to administer pain medication to the resident when they had expressed, they had pain, increased the risk of potential complications of the resident's health and well being.

Sources: Progress Notes, EMARs, and Staff Interviews

[740915]