**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**

**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**

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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 26, 2014 | 2014_256517_0023 | L-000376-14 | Critical Incident System |

**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**

PATRICIA VENTURA (517)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): May 8 & May 9, 2014**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one family member, one Registered Nurse, one Registered Practical Nurse and two Personal Support Workers.**

**During the course of the inspection, the inspector(s) reviewed two resident health records.**

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

**Prevention of Abuse, Neglect and Retaliation**
**Skin and Wound Care**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident or substitute decision maker (SDM) had been given an opportunity to participate fully in the development and implementation of the plan of care for the skin care of resident 001 as evidenced by:

Health record review for resident 001 revealed the resident had a change in skin condition. This resident's health record did not indicate the Power of Attorney was notified of the change in resident skin condition.

Interview with the Power of Attorney for resident 001 revealed the Power of Attorney was not notified of the changes in skin condition.

The Administrator and Director of Care verified the expectation was that the Power of Attorney for resident 001 was contacted with a change in skin condition. [s. 6. (5)]

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**WN #2: 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 a pressure ulcer was assessed by a registered dietitian who was a member of the staff of the home as evidenced by:

Health record review for resident 001 revealed this resident had a pressure ulcer. Further review of the health record for this resident and staff interviews indicated resident 001 was not assessed by a registered dietitian after developing the pressure ulcer.

Registered nursing staff reported the expectation was that residents with pressure ulcers were assessed by a registered dietitian.

The Director of Care verified the expectation was that all residents with pressure ulcers were assessed by a registered dietitian within 7 days of developing the pressure ulcer. [s. 50. (2) (b) (iii)]

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**Issued on this 26th day of May, 2014**

| **Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs** |
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| PATRICIA VENTURA |