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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: February 13, 2023	
Inspection Number: 2023-1533-0003	
Inspection Type: Critical Incident System	
Licensee: Corporation of the County of Bruce	
Long Term Care Home and City: Brucelea Haven Long Term Care Home - Corporation of the County of Bruce, Walkerton	
Lead Inspector Jessica Bertrand (722374)	**Inspector Digital Signature** Jessica F Bertrand Digitally signed by Jessica F Bertrand Date: 2023.02.22 12:46:20 -05'00'
Additional Inspector(s) Kim Byberg (729) Blake Webster (000589) Dianne Tone (000686)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 5-6, 9-13, 2023 and off-site on January 16-17, 2023.

The following intake(s) were inspected:

- Intake #00001104 [Critical Incident (CI) M507-000045-22] related to neglect and improper care.
- Intake #00002261 [CI M507-000030-22], Intake #00006999 [CI M507-000047-22], Intake #00006185 [CI M507-000013-22], Intake #00011637 [CI M507-000054-22], Intake #00011745 [CI M507-000056-22] related to fall prevention and management.
- Intake #00005575 [CI M507-000042-22] related to injury of unknown cause.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

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 has failed to ensure that the Infection Prevention and Control (IPAC) Standard, as issued by the Director, was implemented.

The IPAC Standard for Long-Term Cares Homes, dated April 2022, section 9.1 stated at a minimum, additional precautions shall include point of care signage that enhanced IPAC control measures are in place.

Specifically, the licensee failed to post contact precaution signage at the door of a resident room, where additional precautions were required.

Rationale and Summary
At the time of inspection, it was observed that a resident's room had a Personal Protective Equipment (PPE) cart inside the door of their room. No additional precautions signage was observed on the door or surrounding areas to indicate the need for PPE. The resident's plan of care stated they had a diagnosis that required room signage to be present.

A registered staff member stated that if a resident had the specified diagnosis they would require contact precautions and signage should have been present at the entrance to their room.

When the resident's room did not have contact precautions signage at the entrance to their room, it increased the risk of contamination to staff and visitors when providing direct care to the resident.

Sources: Observations of a resident's door and room at the time of inspection, plan of care for a resident, interviews with a registered staff member, IPAC Lead, Routine Practices and Additional Precautions in all Health Care Settings, 3rd edition, third Revision: November 2012.

[729]

WRITTEN NOTIFICATION: Doors in a Home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that a soiled utility room on a resident care area was kept closed and locked when the room was not supervised by staff.

Rationale and Summary
On two dates during the inspection, it was observed that a soiled utility room in a resident care area was not closed completely and could be easily pushed open.

The Acting Director of Care (ADOC) stated that the door should be closed tightly and locked. They completed a maintenance referral to repair the door. The next day, they stated that the maintenance staff checked the door and did not find any issues.

Four days after the first observation, Inspector #729 observed the same soiled utility room was not closed completely. A staff member demonstrated the door did not close completely as staff left the room. They stated that it was supposed to close and lock automatically when staff leave.

The soiled utility room contained disinfectant chemicals and was to be kept locked and closed when not supervised by staff. There was potential risk to residents when they had access to an unsupervised area that contained disinfectant chemicals.

Sources: Two observations at the time of inspection, interviews with the ADOC, a staff member and the Administrator, record review of email from the ADOC at the time of inspection.

[729]

WRITTEN NOTIFICATION: Home to be Safe, Secure Environment

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5

The licensee has failed to ensure a resident home area was safe and secure for residents.

Rationale and Summary
At the time of inspection, the spa door in a resident home area was observed to be propped open and

unattended with a bathtub full of water.

A staff member stated they left the spa room open for ten minutes before returning. They indicated they typically left the door open when grabbing supplies and when they went to get residents for their bath because it was easier. When the staff member walked away after speaking to inspector #722374, they left the door open before returning with a resident for their bath.

The ADOC stated that it was not appropriate for staff to leave the spa door open when unattended as it was dangerous.

By leaving the door to the spa room open, there was a risk to residents when they had access to an unsupervised area that contained a bathtub full of water.

Sources: Observations on a resident home area at the time of inspection, interviews with a staff member and the ADOC.

[722374]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary:
A resident had a risk of impaired skin integrity and used an assistive device as their primary means of locomotion. The resident's care plan and signage above their bed indicated to remove a transfer aid after being transferred to their assistive device.

On two dates during the inspection, the resident was observed to have a transfer aid still in place while using their assistive device. A clinical consultant stated each time they were in the home the resident had their transfer aid completely out of place.

The ADOC indicated the transfer aid should have been removed as there was a high risk of impaired skin integrity concerns.

Failing to remove the transfer aid when the resident was transferred to their assistive device put them at risk of developing skin and wound concerns.

Sources: A resident's plan of care and bedside signage, observations at the time of inspection, the safe resident handling policy, and interviews with staff members, a clinical consultant, and the ADOC.

[722374]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) Review and revise the home's pain management policy to ensure that there is clear direction to staff as to the steps that should be taken when a resident experiences new or worsening pain. The steps are to include, but are not limited to, assessments to be used, time frames when determining the effectiveness of pain medication, guidance on when to contact the physician and when to send referrals to specialized resources.

b) Ensure that a comprehensive pain assessment is available in the home that is based on best practice and can be utilized for all residents, including those with dementia.

c) Ensure all registered staff and the management team are provided education in relation to the policy revised in part a) and the comprehensive pain assessment in part b)

d) Document the education, as outlined in c), including the date, format, staff who completed the training, and the staff member who provided the education.

Grounds
The licensee has failed to ensure that a resident was not neglected eight days after the onset of pain and unexplained impaired skin integrity concerns and before being diagnosed with a significant injury.

"Neglect is defined as 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. O. Reg 246/22, s. 7.

Rationale and Summary:
A resident was identified to have multiple impaired skin integrity areas and pain to a specific area. The resident experienced a significant amount of pain over the course of eight days after the areas were first discovered. However, no pain assessments beyond severity levels or measurements of one altered skin integrity area was completed. As well, no additional interventions were implemented, the plan of care was not revised to address the resident's pain concerns, and no referrals were completed in relation to such.

As needed pain medication was provided to the resident during this time, with several doses not determined to be effective until a significant amount of time later. The resident continued to demonstrate signs and symptoms of pain during that time. The home's Pain and Symptom Management Policy did not provide clear direction to staff as to when to assess the effectiveness of pain, what specific assessments to use, and when to refer to appropriate individuals.

Several registered staff were informed during this time that the resident's altered skin integrity area did not appear normal and that a significant injury may be present.

A diagnostic test was ordered for the resident during this time, but results were not available until 12 days later. The Director of Nursing (DON) was notified of the impaired skin integrity in a huddle on the same day. The resident's Substitute Decision Maker (SDM) was notified of the delay of receiving the test results but was not informed of the significance of the resident injuries or pain. As a result, the SDM elected not to send the resident to hospital. Further, the physician was not informed of the delay in receiving the testing results or continued usage of pain medication.

Eight days after the skin and pain concerns were brought forward, a registered staff member, who was familiar with the resident, assessed them for the first time. They stated it was obvious something was wrong with the resident, and they suspected a significant injury at that time. The resident was sent to the hospital immediately and was diagnosed with a significant injury. The SDM said they were unaware of how bad the resident's injuries were.

The home did not investigate the incident until eight days after the resident's injuries were identified and six days after the DON was notified. The administrator acknowledged the investigation should have commenced when the DON was initially notified.

Failing to immediately investigate the new onset of pain and impaired skin integrity together with not conducting a comprehensive assessment of a resident's new onset of pain, which required increased usage of as needed medication, contributed to the delay in diagnosis and appropriate treatment. This pattern of inaction combined with not providing the SDM a full picture of the resident's situation, and not communicating changes to the resident's physician, contributed to the harm suffered by the

resident.

Sources: A resident's progress notes, electronic Medication Administration Record, point of care pain documentation, physical chart, care plan, skin and wound assessments, diagnostic testing documentation, interviews with staff members, clinical support staff, and the Administrator, the home's investigation notes, pain experience training documentation, Pain and Symptom Management Policy, Prevention of Abuse Policy, the home's pain bubble sheet, Assessment and Management of Pain in the Elderly (2007) Registered Nurses of Ontario.

[722374]

This order must be complied with by March 24, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch

Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.