Ontario

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

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

Central West District
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Original Public Report

Report Issue Date: April 21, 2023
Inspection Number: 2023-1533-0004
Inspection Type: Follow up 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	**Inspector Digital Signature**
Janis Shkilnyk (706119)	Janis M Shkilnyk Digitally signed by Janis M Shkilnyk Date: 2023.05.01 13:46:46 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 4, 5, 6, 11, 12, 13, 14, 2023

The following intake(s) were inspected:

- Intake: #00004711 - allegation of staff to resident abuse.
- Intake: #00012061 - allegation of resident abuse.
- Intake: #00017756 - fall of a resident resulting in injury.
- Intake: #00020678 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1)

Previously Issued Compliance Order(s)

Order #001 from Inspection #2023_1533_0003 related to FLTCA, 2021, s. 24 (1), was complied.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Contents

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (2) (g)

The licensee has failed to comply with their policy to promote zero tolerance of abuse, when they did not follow the procedures for investigating and responding to allegations of resident abuse.

Rationale and Summary

The licensee's policy, Prevention of Abuse and Neglect of a Resident, directed the nurse to follow the steps outlined in the nursing checklist for investigating actual, alleged or suspected abuse and completing the prevention of abuse and neglect of a resident investigation template, outlining information to be collected during an investigation and documented. The Administrator or designate was to request that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event. They were also supposed to be interviewed. All investigative information was to be kept in an investigation report.

The home submitted a critical incident to the Director related to an allegation of resident abuse. The home's investigation file did not contain the required nursing checklist and resident investigation template related to allegations of abuse towards a resident. There were no written or signed statements and no interviews in the file.

The Acting Administrator stated that they did not see an investigation for this incident and that the home did not follow their policy for an allegation of resident abuse investigation.

The home's failure to follow their prevention of abuse and neglect of a resident policy could have led to potential risk for a resident by not investigating all aspects of the alleged allegations of abuse towards the resident.

Sources:

Interview with Acting Administrator, review of resident's clinical records, investigative file, critical

incident summary, policy VII-G-10.00 Prevention of Abuse and Neglect of a Resident, last revised: 03/2022.

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WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure a resident was protected from abuse by another resident.

"Physical abuse" is defined as the use of physical force by a resident that causes physical injury to another resident. O. Reg. 246/22, s. 2 (1).

Rationale and Summary

A resident told staff that they hit and pushed another resident.

The resident who was pushed was found on the floor and sustained an injury.

Staff stated the resident was upset that they were injured.

This incident of physical abuse caused moderate impact to a resident as they sustained a physical injury when the incident occurred.

Sources:

Review of a resident's clinical records, interview with staff, Critical Incident (CI) review, risk management review for a resident.

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WRITTEN NOTIFICATION: Fall prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident was found on the floor an assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

Rationale and Summary

A resident had an unwitnessed fall and was found on the floor.

There was no post fall assessment completed on the Point Click Care (PCC) assessment page for this fall.

Staff said a post fall assessment should have been completed but was not.

Not completing a post fall assessment for a resident was a missed opportunity for the home to assess for injury related to their unwitnessed fall.

Sources:

Resident progress notes, PCC tab, interview with staff.

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WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.

The licensee has failed to comply with their responsive behaviours program when they did not ensure that written approaches to care, screening protocols and behavioral triggers were identified for a resident.

Rationale and Summary

On a specific day a resident told staff they had responsive behaviours which lead to an altercation with another resident. The Critical Incident (CI) submitted to the Director noted previous altercations between the two residents.

The trigger was not added to the resident's care plan until later.

Staff stated that the resident's care plan had not been updated at the time of the incident and the

identified trigger should have been identified on their care plan prior.

An observation tool was not commenced at the time of the incident.

Staff stated they would have expected observational charting to commence for the resident immediately after the incident and confirmed no observational charting had been commenced.

The home's failure to follow their responsive behaviors program, could have led to potential risk for a resident and other residents by not implementing appropriate interventions related to specific triggers and assessing a potential pattern of their responsive behavior through observation.

Sources:

Review of critical incident, a resident's clinical record, care plan, interviews with staff.

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WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with directions for use specified by the prescriber when a resident did not receive as needed medication for the management of responsive behaviour.

Rationale and Summary

On several occasions during a specific time period a resident demonstrated responsive behaviours. On one of these occasions the resident's behaviors were severe. At the time of all incidents, the resident had been prescribed medication for use as needed to assist with their responsive behaviours. No as needed medications were administered during this time period.

Staff said medications were not administered in accordance with the directions for use specified by the prescriber.

The home's failure to ensure that the resident received medication as directed by the prescriber may have led to the potential further escalation of their responsive behaviors.

Sources:

Review of the resident clinical records, a resident's electronic medication administration record (EMAR), interview with staff.

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