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: September 27, 2023

Inspection Number: 2023-1533-0006

Inspection Type:
Complaint
Critical Incident

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**
Daniela Lupu (758)	Daniela Lupu Digitally signed by Daniela Lupu Date: 2023.10.06 12:46:46 -04'00'

Additional Inspector(s)
Alicia Campbell (741126)
Dianne Tone (000686)
JanetM Evans (659)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28-31, September 1, 5-8, and 11-13, 2023.

The following intake(s) were inspected:
· Intake #00091549, Intake #00091982, and Intake #00092815, related to staffing shortage and resident care.
· Intake #00092425, related to alleged neglect
· Intake #00092431, related to medication management
· Intake #00092525, related to Infection Prevention and Control (IPAC) practices and improper care
· Intake #00094938, related to whistleblowing and retaliation.

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

Resident Care and Support Services

Medication Management
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 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 received a different level of assistance than what was required as per their plan of care.

When the resident's care was not provided as specified in the plan, the resident was put at risk.

Sources: a resident's clinical records and interviews with a PSW and an RPN. [741126]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee failed to ensure that actions taken for a resident under the Skin and Wound program and the resident's responses to these interventions were documented.

Rationale and Summary

A resident needed assistance from staff members with their mobility. Staff were to document in the Point of Care (POC) the resident's self-performance and the support provided every shift and at specified intervals of time if the resident was assisted with the mobility task.

i) In a three-month period, there was missing documentation of the support provided to the resident on several occasions during a specific shift. Additionally, on multiple dates and times during different shifts there was missing documentation to indicate if the resident was assisted with the mobility task.

ii) On one occasion, the staff had difficulty assisting a resident with the mobility task. An RN assisted the resident and noted they needed a higher level of assistance to complete the care. The resident expressed to the RN that they were not satisfied with the care provided by one of the staff.

An RN said they did not document the interventions provided and the resident’s responses, as required.

The DON said the interventions provided to residents and the resident’s responses to the interventions should be documented.

By not documenting the interventions related to a resident’s care and the resident’s responses, it was a risk that staff may not be aware of the interventions provided.

Sources: a resident's clinical records, and interviews with an RPN, RN , and the DON.[758]

WRITTEN NOTIFICATION: Bathing

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee has failed to ensure that two residents were bathed, at a minimum twice a week.

Rationale and Summary

Two residents did not receive their scheduled bath.

By not receiving two baths per week, two resident’s health and hygiene were put at risk.

Sources: two residents' clinical records and interview with two PSWs, a Nurse Manager and the DNC. [741126]

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 (4) (b)

The licensee has failed to ensure that for each resident demonstrating responsive behaviours, strategies were implemented to respond to these behaviours.

Rationale and Summary

A resident needed continuous monitoring from a staff member to assist with managing their responsive behaviours. An assigned team member was to relieve the staff member for their breaks.

On one occasion, the resident did not have continuous monitoring in place during a staff member's break.

By not implementing a resident's monitoring strategy, the resident may exhibit an increase in responsive behaviours.

Sources: an observation of a resident, a resident's clinical records, the home's responsive behaviours policy and attached documents and interviews with a PSW, an RPN and a Nurse Manager. [741126]

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that, for two residents demonstrating responsive behaviours, actions were taken to respond to the needs of the residents, including assessments, reassessments and interventions and that the residents' responses to interventions were documented.

Rationale and Summary

Two residents had changes to the interventions related to their responsive behaviours. These changes were not documented on both residents' plan of care. Any assessments of the residents regarding these changes had also not been documented.

By not documenting assessments of both residents, or the change in the interventions on their plan of care, there was risk that this change would not be communicated to staff.

Sources: two resident's clinical records, and interviews with a PSW, Recreation and Leisure staff, two registered nursing staff and a Nurse Manager. [741126]

WRITTEN NOTIFICATION: Housekeeping

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)

The licensee has failed to comply with procedures for cleaning and disinfecting of resident bedrooms in one of the Resident Home Areas (RHA).

Rationale and Summary

The home's housekeeping policy stated that housekeeping team were to follow each cleaning frequency schedule. The housekeeping cleaning frequency schedule documented that resident bedrooms, including contact surfaces were to be cleaned daily.

On one occasion, all resident bedrooms in one RHA were not cleaned or disinfected as required.

The home's IPAC Lead said that resident bedrooms including high touch areas should be cleaned daily, when the home was not in an outbreak.

By not ensuring that cleaning procedures for resident bedrooms were followed in one of the RHAs increased the risk of spreading harmful microorganisms.

Sources: observations in one of the RHAs, the home's housekeeping cleaning frequencies policy, housekeeping cleaning frequency schedule, and interviews with a resident, four housekeepers, and the home's IPAC Lead. [758]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The licensee has failed to ensure that a complaint related to a resident's care was investigated and a

response was provided to the resident within 10 business days from the receipt of the complaint.

Rationale and Summary

A resident reported concerns related to the care they received from the PSWs.

A Nurse Manager said that an investigation of this complaint was not completed.

The resident was upset that no response on how their complaint was addressed was provided to them.

The DON said all complaints that were received at the home should be investigated and a response provided to the complainant, as required.

By not investigating the complaint related to a resident's care, the root cause of their concerns could not be identified, and appropriate actions could not be implemented.

Sources: a resident's clinical records, the home's complaints policy, and interviews with an RPN, a Nurse Manager, and the DON and other staff. [758]

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee failed to ensure that a documented record that included the nature of a complaint, was kept at the home.

Rationale and Summary

A complaint regarding the operation of the home and care of residents was received by the DON.

There was no complaint record to indicate the nature of the complaint.

The DON said they investigated the concerns, but did not keep a record of the complaint.

By not keeping a record to include details of the concerns, the complaint could not be reviewed and analyzed, and appropriate actions could not be implemented if required.

Sources: a critical incident report, the home's investigation records, the home's complaints records, and an interview with the DON. [758]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (b)

The licensee failed to ensure that a documented record that included the date of a complaint, was kept at the home.

Rationale and Summary

The complaint specified in NC #008 was received by the DON.

There was no complaint record to indicate the date when the complaint was received.

Sources: a critical incident report, the home's investigation records, the home's complaints records, and an interview with the DON. [758]

WRITTEN NOTIFICATION: Dealing with complaints

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)

The licensee failed to ensure that a documented record that indicated the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action related to a complaint, was kept at the home.

Rationale and Summary

The complaint specified in NC #008 was received by the DON.

There was no complaint record to include the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action.

Sources: critical incident report, the home's investigation records, the home's complaints records, and an interview with the DON. [758]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)

The licensee failed to ensure that a documented record that included the resolution of a complaint, was kept at the home.

Rationale and Summary

The complaint specified in NC #008 was received by the DON.

There was no complaint record to indicate the resolution, if any, of the complaint.

Sources: a critical incident report, the home's investigation records, the home's complaints records, and an interview with the DON. [758]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed of a respiratory outbreak.

Rationale and Summary

A respiratory outbreak was declared at the home by the Public Health Unit (PHU).

The outbreak was not reported to the Director until one day later.

By not reporting the respiratory outbreak immediately to the Director, it may delay the Director's ability to respond to the incident in a timely manner.

Sources: a critical incident report, and an interview with the home's IPAC Lead. [758]

WRITTEN NOTIFICATION: Administration of Drugs

NC #013 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 no drug was administered to a resident unless the drug has been prescribed for them.

Rationale and Summary

An RPN administered the wrong medication to a resident.

As a result, the resident required additional medical interventions.

Sources: a critical incident report, a medication incident report, a resident's clinical records, and an interview with an RPN. [000686]

COMPLIANCE ORDER CO #001 Nursing and Personal Support Services

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)

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

1) Conduct an interdisciplinary assessment of a resident's care needs, specifically, the level of assistance they require with care, including the two identified Activities of Daily Living (ADLs).

2) Update the resident's plan of care to reflect:
   i) The resident's reassessed care needs.
   ii) The resident's choices related to the two identified ADLs.

3) Review the staffing complement on the Resident Home Area (RHA) where the resident resides, with the interprofessional team and ensure there is a written staffing plan for personal support services to meet the resident's assessed care needs as indicated above, combined with the needs of the rest of the RHA.

4) Ensure a written record is kept of all steps outlined above, including dates, participants, and documentation of what was discussed and the outcome.

Grounds

The licensee has failed to ensure that the home's staffing plan for personal support services provided a staffing mix consistent with a resident ’s assessed safety and care needs.

Rationale and Summary

A resident needed assistance from staff members with two specific ADLs. The resident's plan of care documented that one of those ADLs was to be provided at a specified frequency when the resident requested, and staff were to set up plans of when this would occur.

The Personal Support Workers (PSWs) complement on the Resident Home Area (RHA) where the resident resided, did not provide sufficient staff to meet the assessed resident care needs related to the two ADLs.

Over a three-month period, on a few occasions, the resident did not receive assistance with the two ADLs, while on multiple occasions, they received assistance a few days later, when additional PSWs were scheduled to work.

An RPN said the resident could not receive assistance for the two specific ADLs when they requested it, unless it was pre-planned to provide one additional PSW. They said no plan was in place or communicated to staff.

The DON and a Nurse Manager acknowledged there was no plan in place to meet the resident’s care needs related to the two specific ADLs. A Nurse Manager said the resident ’s care plan should be updated to reflect the accurate care needs.

By not having a written staffing plan for personal support services to meet the resident’s assessed care needs related to the two specific ADLs, the resident’s choices were not respected, and the resident felt sad and helpless.

Sources: a resident’s clinical records, nursing staffing daily complement on one of the RHAs, and interviews with a resident, three PSWs, an RPN, a Social Worker, a Nurse Manager, and the DON. [758]

This order must be complied with by October 27, 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.