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
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Original Public Report

Report Issue Date: September 24, 2024

Inspection Number: 2024-1533-0004

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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 20 – 23 and 26 - 30, 2024.

The following intakes were inspected in this Critical Incident (CI) Inspection:

- Intake: #00118886 was related to falls prevention and management
- Intake: #00121623 was related to allegation of resident abuse
- Intake: #00123210 was related to falls prevention and management

The following intakes were inspected in this Complaint inspection:

- Intake: #00119537 was related to falls prevention and management
- Intake: #00123257 was related to laundry service, staffing levels, family council, and resident care and services

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

Resident Care and Support Services

Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

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)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from abuse by a staff member.

For the purpose of this Act and Regulation, "sexual abuse" means: any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

Rationale and Summary
An incident occurred where a resident was inappropriately touched.

The licensee failed to protect the resident from abuse resulting in the resident being

negatively impacted by the incident.

Sources: A resident's clinical records, the home's investigation notes, the home's Prevention of Abuse & Neglect of a Resident Policy (Policy Number VII-G-10.00, last revised February 2024), and interviews with the resident and staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to comply with their policy to promote zero tolerance of abuse, when a Registered Practical Nurse (RPN) was notified of the allegation of abuse of a resident by a staff member and did not take further action as required in the home's policy.

Rationale and Summary:
The home's Prevention of Abuse & Neglect of a Resident policy (Policy number VII-G-10.00, last revised February 2024), directs nursing staff to check on the resident's condition to assess their safety and emotional and physical wellbeing and to notify the administrator or designate regarding the allegation of abuse.

An RPN was notified of an allegation of abuse towards a resident. The RPN did not complete any assessments of the resident or report this allegation of abuse to

management of the home. The RPN confirmed they did not document the incident when they were notified.

The RPN failing to take action when they were notified of an incident of abuse, delayed the necessary treatment and follow up action required for the resident.

Sources: A resident's clinical records, the home's investigation notes, the home's Prevention of Abuse & Neglect of a Resident policy (Policy Number VII-G-10.00, last revised February 2024), and interviews with the resident and staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the alleged abuse of a resident was immediately reported to the Director.

Pursuant to s. 154 (3), the licensee is vicariously liable for a staff member failing to comply with subsection 28 (1).

Rationale and Summary
A Personal Support Worker (PSW) was notified by a resident of an incident of

alleged abuse. Subsequently, the PSW notified the Registered Practical Nurse (RPN) of the alleged abuse incident.

When the RPN was notified of this allegation of abuse, they did not report this allegation of abuse to management of the home or the Director.

The failure of the home to report this incident immediately may have delayed the Director in responding to the incident.

Sources: A resident's clinical records, the home's investigation notes, the home's Prevention of Abuse & Neglect of a Resident policy (Policy Number VII-G-10.00, last revised February 2024), and interviews with the resident and staff.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

The licensee failed to ensure the staffing compliment required as per the Job Routine Plan was present on the unit, when a resident sustained a fall.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure,

strategy, initiative or system was complied with.

The Job Routine Document indicated that only one Personal Support Worker (PSW) is to go to break at a time leaving two PSW's on the unit at all times.

Rationale and Summary
On a day in June 2024, there was only one PSW staff member on the unit.

As per the home's Job Routine Document it indicated that each PSW goes to break one at a time therefore always leaving two PSW's on the unit. On this date, three PSW's and the Registered Nurse (RN) all left the unit at the same time leaving one PSW to manage and monitor all the residents on the unit.

The Director of Nursing (DON) reported that there should have been at least two PSW staff on the unit at all times.

Failure to have the staffing compliment present on the unit put residents at risk for decreased monitoring.

Sources: Job Routines Document, a resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe

transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that a resident was transferred from the floor using a mechanical lift after an unwitnessed fall.

The home's Falls Prevention and Management Policy (Policy number VII-G-3-.10, last revised August 2024) indicated that when a resident had a fall that they are lifted off the floor with the use of a mechanical lift as per the home's zero lift procedure.

Rationale and Summary
A resident sustained an unwitnessed fall and was found on the floor.

A Registered Nurse (RN) reported that the resident was physically lifted by two staff members from the floor and placed on the bed. At the time of the transfer, the resident was unable to weight bear and was experiencing pain.

The Director of Nursing (DON) reported that the staff did not transfer the resident according to the home's Falls Prevention and Management policy regarding zero lifts.

When staff did not follow safe transferring techniques as outlined in the policy, it posed a risk for injury.

Sources: Falls Prevention and Management Policy (VII-G-30.10, Last revised August 2024), Zero Lift Definition document, a resident's clinical records, and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including monitoring resident #001 post-fall.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that the home's Falls Prevention and Management policy was complied with.

As per the home's Falls Prevention and Management policy, Policy Number VII-G-30.10, last revised August 2024, stated that registered staff are to initiate a head injury routine if the resident's fall is unwitnessed.

Rationale and Summary
A resident sustained an unwitnessed fall and was found on the floor. The head injury routine assessment for the resident was not completed post-fall.

The DON confirmed that a head injury routine assessment was not completed for the resident after their fall and it should have been.

When the resident did not receive head injury routine monitoring after their

unwitnessed fall, they were at risk of undetected injury.

Sources: Falls Prevention and Management Policy (VII-G-30.10 - Last revised August 2024), a resident's clinical records, and interviews with staff.