Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 3, 4, 5, 6, 11, 17, 24, 2011	2011_034117_0028	Critical Incident

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET, OTTAWA, ON, K1N-5C8

Long-Term Care Home/Foyer de soins de longue durée

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA, OTTAWA, ON, K1C-2Z6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Clinical Programs, to the home's two Directors of Care, to several Registered Nurses (RN), to several Registered Practical Nurses (RPN), to several Personal Support Workers (PSW), to resident family members and to the several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of four identified residents and examined several resident rooms.

The following Inspection Protocols were used during this inspection:

Pain

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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.) 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. 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 subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. An identified resident suffers from dementia. Since early September 2011, the resident has been demonstrating increased wandering, exit seeking behaviours, verbal and physical aggression towards staff providing care.

On identified dates in September 2011, the resident was agitated, restless; actively exit seeking as well as verbally and physically aggressive with evening staff as per progress notes and behaviour mapping documentation. The resident's plan of care does not identify behavioural triggers except for agitation on evening. Prescribed medication intervention for agitation was not administered as per plan of care.

2. On an identified date in September 2011, the resident had a change in health status. The resident's attending physician decreased the resident's narcotic pain medication for seven days.

On an identified day in September 2011, the attending physician discontinued the resident's narcotic pain medication and ordered that the resident's pain be assessed and monitored every shift. A narcotic medication was also ordered to be given as needed (PRN).

A day shift RPN stated during an interview that she did observe the resident have facial grimacing during repositioning on evening. The RPN stated that she did not give the prescribed PRN narcotic medication for pain as the resident was already receiving regularly prescribed analgesic medication. No PRN narcotic medication was given for pain on identified dates in September 2011. No evidence of pain assessment, monitoring or documentation, as per medical orders, was noted in the resident's health care record, behaviour mapping or in the unit shift reports.

3. The resident's revised plan of care, post incident on an identified day in September 2011, does not identify the resident's ongoing verbal and physical aggression towards staff and other residents. Behavioural triggers and resident specific behavioural interventions, that give clear directions to staff and others who provide direct care to the resident, are not identified.

The plan of care does not identify the potential for pain, discomfort and need for monitoring since the discontinuation of narcotic medication, as per physician orders.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

An identified resident suffers from dementia. Since early September 2011, the resident has been demonstrating increased wandering, exit seeking behaviours, verbal and physical aggression towards staff providing care.

On identified dates in September 2011, the resident was agitated, restless; actively exit seeking as well as verbally and physically aggressive with evening staff as per progress notes and behaviour mapping documentation. Plan of care does not identify behavioural triggers except for agitation on evening. Prescribed medication intervention for agitation was not administered as per plan of care.

On identified dates in September 2011, the resident was agitated, restless, actively exit seeking as well as verbally and physically aggressive with evening staff as per progress notes and behaviour mapping documentation. Prescribed medication intervention for agitation was administered with no effect on resident's agitation and behaviours. Plan of care interventions were not reassessed when these were noted to be ineffective.

On an identified date in September 2011, the evening RPN documents that the resident's current plan of care interventions were not effective and need to be reassessed due to increased evening behaviours. As per resident care records, shift reports, unit RPN and DOC interviews, the resident's care interventions were not reviewed until after an incident that occured in late September.

On an identified date in September 2011 the evening RPN documents that the evening shift RN was notified of the resident's ongoing agitation, exit seeking and aggressive behaviours even with the administration of prescribed medication. According to the RPN, the evening RN did not reassess the resident's behaviours and interventions that evening and no documentation could be found to indicate such reassessment.

On an identified date in September 2011, the resident was found wandering the resident care unit in a state of agitation. His / her hands had blood on them. When examined, no injuries were noted. Night time nursing staff noted that three other residents were injured in their beds.

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 27th day of October, 2011

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117)
Inspection No. / No de l'inspection :	2011_034117_0028
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Oct 3, 4, 5, 6, 11, 17, 24, 2011
Licensee / Titulaire de permis :	BRUYERE CONTINUING CARE INC. 43 BRUYERE STREET, OTTAWA, ON, K1N-5C8
LTC Home / Foyer de SLD :	RESIDENCE SAINT- LOUIS 879 CHEMIN PARC HIAWATHA, OTTAWA, ON, K1C-2Z6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CARL BALCOM

To BRUYERE CONTINUING CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 901

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The home shall ensure that for the resident who is demonstrating responsive behaviours,
- the behavioural triggers for the resident are identified where possible
- that strategies be developed and implemented to respond to the resident's behaviours where possible
- that appropriate actions are taken to reassess interventions in a timely manner if they are not effective

Grounds / Motifs :

1. An identified resident suffers from dementia. Since early September 2011, the resident has been demonstrating increased wandering, exit seeking behaviours, verbal and physical aggression towards staff providing care.

On identified dates in September 2011, the resident was agitated, restless; actively exit seeking as well as verbally and physically aggressive with evening staff as per progress notes and behaviour mapping documentation. Plan of care does not identify behavioural triggers except for agitation on evening. Prescribed medication intervention for agitation was not administered as per plan of care.

On identified dates in September 2011, the resident was agitated, restless, actively exit seeking as well as verbally and physically aggressive with evening staff as per progress notes and behaviour mapping documentation. Prescribed medication intervention for agitation was administered with no effect on resident's agitation and behaviours. Plan of care interventions were not reassessed when these were noted to be ineffective.

On an identified date in September 2011 the evening RPN documents that the resident's current plan of care interventions were not effective and need to be reassessed due to increased evening behaviours. As per resident care records, shift reports, unit RPN and DOC interviews, the resident's care interventions were not reviewed until after an incident that occured in late September.

On an identified date in September 2011 the evening RPN documents that the evening shift RN was notified of the resident's ongoing agitation, exit seeking and aggressive behaviours even with the administration of prescribed medication. According to the RPN, the evening RN did not reassess the resident's behaviours and interventions that evening and no documentation could be found to indicate such reassessment.

On an identified date in September 2011, the resident was found wandering the resident care unit in a state of agitation. His / her hands had blood on them. When examined, no injuries were noted. Night time nursing staff noted that three other residents were injured in their beds. (117)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of October, 2011

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNE DUCHESNE

Service Area Office /
Bureau régional de services : Ottawa Service Area Office