Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 29, 2016	2016_289550_0025	013692-16	Complaint

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

JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 21, 22, 27, 28, 29, 30, July 4, 5, 6, 7 and 8, 2016.

This inspection complaint inspection is related to a complaint regarding personal care services to a resident. The inspection was conducted at the same time as logs #008860-16, #008256-16 and #010582-16.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Administrator/Clinical manager, the Director of Care (DOC), several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), resident and family.

In addition, the inspector reviewed resident health care records and staff and resident interaction.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident.

Resident #002 was admitted to the home in early 2012 with multiple diagnosis and is dependent of staff for all activities of daily living.

During an interview, resident #002's daughter who visits on a daily basis indicated to the inspector that she often finds the resident in the dining room without his/her upper denture in place and the resident's hands dirty with yellowish matter on fingers and nails. She further indicated she has asked staff to remove the mesh sling from under the resident after he/she is transferred to the wheelchair as the straps are all bunched up between the resident's legs and she feels this may be uncomfortable.

On June 22, 2016 the inspector observed the resident sitting in a wheelchair in the dining room for breakfast. The resident did not have his/her upper denture in place. The inspector observed the resident's upper denture was in a denture cup on the night table in the resident's room. There was no water in the denture cup; the denture was dry with white dried matter on it.

On June 27, 2016 the resident's daughter arrived to feed the resident and there were 2 metal soup spoons to feed the resident. She indicated to the staffs that small plastic disposable spoons are to be used to make it easier on her mother when eating.

On June 30, 2016 the inspector observed the resident sitting in a wheelchair in the dining room. The resident had dry yellowish matter under and around nails on left hand.

On June 22, 27, 30 and July 5, 2016 the inspector observed the resident sitting in a wheelchair in either the bedroom or the dining room. The mesh sling used to transfer the resident with the ceiling track was still under the resident; it was not removed.

During an interview, PSW #S109 and RPN #S117 indicated to the inspector the resident often refuses to have dentures put in and have his/her hands washed. The resident becomes physically aggressive and agitated if staff tries to encourage him/her. The Administrator/Clinical manager indicated to the inspector this was reported to her.

Inspector #550 reviewed the resident's written plan of care and observed that there is no

indication that the resident is resisting to care regarding wearing dentures, hand washing before meals and the removal of the mesh sling after transfers. There is no provision in the plan of care to indicate that the resident needs to be fed with plastic spoons.

During an interview, the Administrator/Clinical manager and the DOC indicated being informed by registered staff and personal support workers that the resident is resistant to care and requires to be fed with plastic spoons and that this should be documented in the resident's plan of care. [s. 6. (1) (a)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (a) procedures are developed and implemented to ensure that, (iv) there is a process to report and located residents' lost clothing and personal items.

During an interview, resident #002's daughter indicated to Inspector #550 that the resident's lower denture went missing sometime between March 30th after supper and April 1st at lunchtime when she noticed herself that they were missing. She was only informed that it was missing 48 hours after staff had noticed. Because of the tardiness in informing her, she was not able to verify the resident's garbage can and the laundry basket in an attempt to find them. Resident #002's lower denture was never found.

During an interview, the Administrator/Clinical manager indicated to the inspector the home does not have procedure developed and implemented regarding lost items. It was her expectation that staff inform resident #002's daughter immediately when they noticed the resident's lower denture was missing.

As such, the licensee does not have procedures developed and implemented to ensure that there is a process to report and locate lost personal items. [s. 89. (1) (a) (iv)]

Issued on this 13th day of September, 2016

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

Original report signed by the inspector.