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
Feb 22, 2017	2017_619550_0003	023810-16	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): February 8 and 9, 2017.

Off-site inspection conducted on February 17 and 21, 2017.

This Complaint Inspection is related to a complaint regarding personal support services and skin and wound.

During the course of the inspection, the inspector(s) spoke with the Administrator/Clinical Manager, the Director of Care, the Registered Dietician, several Registered Nurses (RN), several Personal Support Workers (PSW), several residents and a family member.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM was provided with the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was received related to resident #001's denture being lost and the resident's substitute decision maker (SDM) not being informed.

During an interview resident #001's SDM told Inspector #550 that he/she visited the resident on a specific day in 2016 during the day and that at that time the resident had his/her upper denture in place. When the SDM returned to visit the resident three days later, the upper denture was missing. The SDM stated that although staff were made aware a few months ago that he/she wants to be informed of missing items, no one informed him/her when the upper denture went missing. Had he/she been made aware of this, he/she would have come to the home to search for it. As a result of this, resident #001 no longer has dentures.

The inspector reviewed the investigation report for the complaint the SDM lodged with the Administrator/Clinical Manager regarding resident #001's lost upper denture on a specific date in 2016. It was documented by the Administrator/Clinical Manager that the resident's upper denture was noted to be missing on a specific date in 2016 by the day PSW and that the RPN was going to inform the resident's SDM when he/she visited as he/she usually visits on a daily basis.

During an interview, the Administrator/Clinical Manager indicated to the inspector that the staff did not inform the resident's SDM when they noticed that resident #001's upper denture went missing because he/she usually visits on a daily basis but when he/she did not visit on that day, no one thought of calling him/her.

Resident #001's SDM was not provided with the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #001's SDM is informed when staff become aware that any personal items of the resident are missing, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate instrument that is specifically designed for falls.

A complaint was received related to a fall of resident #001 and no assessment being conducted.

During an interview Resident #001's SDM informed Inspector #550 that it was reported to him/her by another resident that resident #001 had sustained a fall on a specific date in 2017 during an emergency situation. The SDM further indicated being upset that the resident was not assessed by anyone after the fall and that he/she now has a specific injury to a specific body part.

The inspector observed resident #001 sitting in his/her wheelchair in his/her room. The resident is cognitively impaired and is unable to report events or facts. The inspector

observed that the resident had a specific injury to a specific body part.

During an interview, the Administrator/Clinical Manager indicated to the inspector that she was made aware of the incident by the DOC upon her return to work on February 1, 2017 and that she had not completed her investigation. She indicated that she was unable to determine at this time if the resident had fallen.

Resident #002 is alert and oriented. During an interview, resident #002 informed Inspector #550 that he/she witnessed resident #001 falling off the wheelchair to the floor during an emergency situation on a specific date. The resident recounted that he/she was in the hallway near the elevator when he/she saw resident #001 fall to the floor. He/she said resident #001 was in the hallway in front of the Chapel area on the 3rd floor. Resident #002 told inspector he/she yelled to inform staff that the resident had fallen and then staff picked the resident up from the floor, put him/her back in the wheelchair and fastened the seat belt.

Inspector reviewed the resident's health care records and was unable to find that the resident had been assessed and a post fall assessment was conducted after the fall on a specific date in 2017.

During an interview, RN #100 indicated to the inspector that between a period of two specific hours on a specific date in 2017, she was in the Auditorium on the main floor of the home with the Nursing Supervisor from St-Vincent hospital who was there to assist during the emergency situation when resident #002 told them that resident #001 had fallen off the wheelchair earlier. RN #100 told the inspector that the Nursing Supervisor from St-Vincent Hospital told her that resident #001 would need to be examined and a follow-up would need to be done with the resident's family physician. She indicated that she went to see the resident and did a visual check of the resident but did not remove the blanket that was covering the resident or clothes. She said she did not do a complete assessment as the Nursing Supervisor from St-Vincent Hospital did not tell her to do it right away. She did not do any follow-up with the resident or inform the nurse on duty because the nurse on duty was on another unit and RN #100 was in the basement.

The DOC indicated to the inspector during an interview on February 21, 2017, that a Post Fall Huddle assessment tool is to be conducted after every resident fall and injuries documented on the Post Fall Huddle tool and within the care plan.

After RN#100 was informed by Resident #002 that Resident #001 had sustained a fall,

the resident was not assessed and a post-fall assessment was not conducted using a clinically appropriate instrument that is specifically designed for falls. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has a fall, a post-fall assessment is conducted using a clinically appropriate instrument specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A complaint was received related to resident #001 having a large bruise on the knee and not being assessed.

During an interview, resident #001's SDM informed Inspector #550 that it was reported to him/her by another resident that resident #001 had sustained a fall on a specific night. The resident's SDM told inspector that during the evening while providing care to the resident, the resident told him/her ''bobo''. When he/she examined the resident, he/she noticed the resident had a specific injury to a specific body part and showed it to RN #101. The RN told the SDM she would do a follow-up but never returned. The SDM informed the inspector that he/she had to call the Nurse Practitioner himself/herself the following day to have her come assess resident #001 as he/she was concerned that it may be related to a fall and that no one had assessed it.

The inspector observed resident #001 sitting in a wheelchair in his/her room. The resident is cognitively impaired and is unable to report events or facts. The inspector observed that the resident has a specific injury to a specific body part.

During a review of the resident's health care records, the inspector was unable to find documentation indicating that a skin assessment had been conducted other than the Nurse Practitioner's assessment that was done on a specific date after the resident's SDM had called her.

During an interview, RN #101 who was the RN in charge of resident #001's unit on that specific date, indicated to the inspector that resident #001's SDM showed him/her the bruise on the resident's knee on a specific evening. She told the inspector that she did not conduct a skin assessment or document the specific injury at the time as she was preoccupied with another issue and forgot to make a note later.

As evidenced above, resident #001 who was experiencing altered skin integrity did not receive a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is exhibiting altered skin integrity, the resident is assessed by a member of the registered nursing staff using a clinically appropriate instrument specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are offered and available at each meal and snack.

On February 8, 2017, Inspector #550 observed the meal service for resident #001. The resident was provided with a tray service and fed by a PSW in his/her room because of an acute illness. On the resident's tray, there was a soup, the main meal, a desert and a 120 ml plastic container labelled thickened water. The inspector observed the meal service for that resident for approximately 60 minutes and observed the resident being fed a few teaspoonful of the thickened water throughout the entire meal. No other liquid observed on the tray or offered to the resident. When questioned, PSW #103 told the inspector that the resident usually has two glasses of specific juices and milk with his/her meal on top of the water but that she did not bring those today because of the resident's acute illness.

A review of the resident's current plan of care indicated that the resident will improve intake to 1500cc's of liquid per 24 hours and to offer additional fluids. A review of the electronic documentation for a specific seven day period in 2017 indicated that the resident consumed an average of 857mls of liquids per 24 hours in that period of time.

During an interview, the Registered Dietician indicated to the inspector that 120mls of liquid plus the soup is not sufficient for the resident at mealtime especially that he/she had an acute illness at the time. She further stated that there are always different juices, milk, tea and coffee available at every meal to all residents as per their menu and that these liquids are also offered in thickened consistency. She stated the PSW when preparing the tray for resident #001 should have brought other liquids to offer the resident. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #001 is offered the planned menu items at each meal and snack, specifically related to fluids, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was given sufficient time to eat at his/her own pace.

A complaint was received regarding the meal service for resident #001.

Resident #001 has been living in the home since 2012 and is diagnosed with multiple medical conditions. The resident is unable to feed self and requires a specific textured diet.

A review of the resident's current plan of care indicated under eating that the resident requires to be fed slowly by staff.

On February 8, 2017, Inspector #550 observed the meal service for resident #001. The resident was to eat in his/her room that day because of an acute illness. The inspector was in the resident's room at approximately 1210 hours when PSW #102 entered the resident's room with a meal tray and indicated to the inspector that she was coming to feed the resident.

The PSW sat next to the resident and proceeded to feed the resident his/her soup. The inspector observed that the resident is a very slow eater and requires much cueing to open his/her mouth. Because of specific issues, the PSW had to wipe the resident's face often. The PSW told the inspector that this resident is very slow to eat and that it can take up to thirty minutes to feed the resident. When the soup was approximately 75% consumed, the PSW removed the bowl of soup and proceeded to feed the resident the main meal. She indicated to the inspector that she preferred that the resident ate the

main meal. The main meal consisted of mashed potatoes, bread, vegetables and meat all in a specified texture covered with gravy. Approximately 60 minutes into the meal, when the resident had consumed all the bread, vegetables and half of the meat and potato portion, the PSW put the main meal aside and proceeded to the feed the resident the desert. The inspector did not observe the resident motioning that he/she did not want the main meal anymore and questioned why the PSW had stopped feeding the resident the main meal. The PSW indicated that she wanted the resident to eat the desert and that there was no gravy left in the plate further telling the inspector that the mashed potatoes and the specified texture meat would be too dry to swallow without the gravy. After confirming to the inspector that there was no requirement in the resident's care plan to feed the resident's main meal with gravy, the PSW put the desert aside and continued to feed the resident the main meal. At this time another PSW was heard by the inspector calling PSW #103's name in the hallway looking for her. The PSW came to the resident's room and asked PSW #103 what she was doing as it was time to put the other resident's to bed.

As evidenced above, Resident #001 was not provided with sufficient time to eat at his/her own pace. [s. 73. (1) 7.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #001 is provided with sufficient time to eat his/her meal at his/her own pace, to be implemented voluntarily.

Issued on this 22nd day of February, 2017

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

Original report signed by the inspector.