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 prévue 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 7, 2019	2019_583117_0007	015781-18, 016586-18, 028204-18, 030419-18, 031338-18, 031551-18, 000684-19	Critical Incident System

Licensee/Titulaire de permis

Bruyère Continuing Care Inc.
43 Bruyère 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 System inspection.

This inspection was conducted on the following date(s): January 30, 31, February 1 and 5, 2018

The following critical incidents were inspected:
• Log #015781-18- critical incident (#C567-000032-18) related to a resident fall with injury requiring a transfer to hospital for assessment
• Log #016586-18 - critical incident (#C567-000033-18) related to a resident fall with injury requiring a transfer to hospital for assessment
• Log #028204-18- critical incident (#C567-000041-18) related to a resident's unexpected death
• Log #030419-18- critical incident (#C567-000043-18) related to an incident of resident to resident physical abuse
• Log #031338-18- critical incident (#C567-000044-18) related to an incident of resident to resident physical abuse
• Log #031551-18- critical incident (#C567-000045-18) related to a resident fall with injury requiring a transfer to hospital for assessment
• Log #000684-19- critical incident (#C567-000001-19) related to a resident's unexpected death

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), several housekeeping staff members, a Royal Ottawa Hospital Psychogeriatric Outreach Nurse as well as several residents.

During the course of the inspection, the inspector(s) reviewed several residents' health care records, observed the provision of resident care and services, observed residents mobility aides, bed systems, fall prevention interventions and resident rooms.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. (Log # 015781-18)

Resident #002 has advanced dementia. The resident ambulated independently with no ambulatory aids, however they did have an unsteady gait and were identified as being at high risk for falls. On a specified date in 2018, the resident had unwitnessed fall and sustained an injury. The resident was sent to hospital for assessment and returned to the home with a diagnosed injury.

On February 1 and 5, 2019, resident #002 was observed to be seated in a wheelchair with a 2- point lap belt in place. It is also noted that on February 1, 2019, nursing staff were observed to provide one person assistance to the resident to ambulate on the resident care unit when the resident presented with increased agitation when seated in the wheelchair. RPN# 111, PSWs #112 and #113 said to the inspector that the resident uses a wheelchair with a lap belt in place as a personal assistance services device (PASD). They stated that the resident has been using the wheelchair and lap belt on a daily basis as a fall prevention intervention since the resident's above specified 2018 fall. RPN #111 and PSW #112 said that the resident is still able to ambulate with one staff assistance on the unit. The PSWs said that they ambulate the resident on a regular basis as this helps to decrease / prevent resident agitation and restlessness when the resident is seated for a prolonged period of time in the wheelchair.

A review of the resident's health care record, plan of care in place at the time of the specified fall and current plan of care was conducted. It was noted that the resident's mobility and fall risks had been assessed by occupational therapy (OT) and physiotherapy (PT) services before and after the resident's identified 2018 fall. On a specified day in 2018, two weeks prior to the fall, the occupational therapist (OT) identified that the resident had a loaned wheelchair with lap belt in place as PASD as one of several fall management interventions. On a specified date, two months after the fall, the OT noted that the resident was ambulating independently and did not require the use of a wheelchair. Reviewed progress notes from the time of the fall to present note that the resident regularly uses a wheelchair with lap belt and that the resident requires one person assistance with their mobility on the unit. The resident's current plan of care does not identify resident #002's changed mobility needs, the use of a wheelchair nor the use of a lap belt PASD as a fall prevention intervention. The plan of care also does not identify that the resident has periods of agitation and restlessness as reported by staff nor does it identify interventions for these behaviours.

RN # 110 said to the inspector that a wheelchair and lap belt had been in use as fall prevention interventions for resident #002 since after the resident's identified fall in 2018. RN #110 was aware of the OT assessment for the wheelchair and PASD use but not of the reassessment done two months later indicating that the resident no longer needed the wheelchair and would seek another OT wheelchair consultation for a reassessment of the resident's wheelchair and lap belt use. RN #110 confirmed that the resident is still ambulatory with one person assistance. However, due to the resident's high risk of falls, a wheelchair with lap belt is being used as a fall prevention intervention on a daily basis. RN #110 did say that the resident has frequent periods of agitation and restlessness when seated in the wheelchair and that regularly mobilizing the resident helps with the management of these behaviours. RN #110 did say that the resident's periods of agitation, need for mobility assistance, wheelchair and PASD use are not identified in the resident's plan of care. The home's DOC said that any changes to a resident's mobility, behavioural and fall management interventions are to be included in the resident's plan of care to ensure that staff are providing a consistent approach to care as well as the different aspects of care are integrated and complement each other. [s. 6. (4) (a)]

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 the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

Issued on this 7th day of February, 2019

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

Original report signed by the inspector.