

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

**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**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jul 10, 2019	2019_583117_0033	010395-19	Complaint

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**Licensee/Titulaire de permis**

Bruyère Continuing Care Inc.  
43 Bruyère Street OTTAWA ON K1N 5C8

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

Residence Saint-Louis  
879 Chemin Parc Hiawatha OTTAWA ON K1C 2Z6

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

LYNE DUCHESNE (117)

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**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): July 8, 2019**

**This inspection related to a complaint Log # 010395-19 regarding the provision of resident care and services.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a Registered Nurse (RN), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), to the Behavioural Support Ontario Personal Support Worker (BSO PSW), an identified resident as well as a family member.**

**During the course of the inspection, the inspector reviewed an identified resident's health care record, observed the provision of resident care and services, reviewed licensee complaint documentation.**

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

**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**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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 the plan of care set out clear directions to staff and others who provide direct care to the resident

Resident #001 has several medical conditions and requires staff assistance for the provision of personal care. The resident's current plan of care identifies that resident #001 requires staff assistance with an aspect of personal grooming and the application of personal aids.

As per resident's Substitute Decision Maker (SDM), the resident has been seen on several instances during the past few weeks to have not been provided personal care assistance and personal aids were not correctly applied, as per the plan of care.

Reviewed the resident #001's plan of care with the unit RN #104, RPNs #102 and #105 and BSO PSW #103. They report that the resident has been presenting with some behavioural changes in the past few weeks whereby the resident removes the personal aids, even when these are applied by staff and they need to monitor the behaviours and reapply the aids when removed. They also note that a member of the resident's family provides assistance with an aspect of personal grooming for the resident several times a week but are unsure as to the when this family member visits. The resident confirmed with the inspector that they are provided grooming assistance by their visiting family member.

The DOC indicated that the home's nursing team has reported to her that the resident has been presenting with behavioural changes in the past few weeks. Plan of care interventions were not reviewed and revised to provide clear direction regarding these new behaviours, the application and monitoring of the resident's personal aids. The DOC also indicated that the plan care does not provide clear direction to staff in regards to the resident's grooming needs and the family's assistance with care. [s. 6. (1) (c)]

***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 plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

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Issued on this 10th day of July, 2019

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

**Original report signed by the inspector.**