Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2019	2019_818502_0023	015033-19	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

JULIENNE NGONLOGA (502)

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): October 8, 9 and 10, 2019.

During the course of this inspection Critical Incident System Reports (CIS) #567-000019-19 (log # 015033-19) related to multiple care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs).

During the course of this inspection, the inspector(s) observed the resident care, staff and resident interactions, interviewed staff, and reviewed the residents' health care records, home's record, staff schedules, the licensee investigation notes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Critical Incident System report (CIS) was received by the Ministry of Long-Term Care (MLTC) related to multiple care concerns.

A review of the written complaint's letter submitted with the CIS report indicated that identified cares were not provided to resident #001.

Review of the resident's written plan of care for an identified month in 2019 indicated that resident #001 had their own teeth on the bottom and required total assistance of one staff. The written plan of care outlined procedures for the specified care.

Review of resident #001's Document Survey Report for the identified month in 2019, did not identify completed documentation for the specified care provided on multiple days and shifts.

Further review of the resident's written plan of care indicated that resident #001 required total assistance of two staff and use an identified equipment during a specified care twice weekly. The written plan of care outlined procedures for the specified care

Review of the Document Survey Report for the identified month in 2019 did not identify completed documentation the specified care provided four times during the period identified above.

In separate interviews, PSWs #101, #102, #103 and RPN 100 indicated that the resident was dependent on staff for all cares. They indicated that the care was provided as per plan, but they did not have time at the end of their respective shifts to document the care that was given.

In an interview, the Director of Care verified that the care was provided to the resident daily, but the staff did not document consistently. [s. 6. (9) 1.]

Issued on this 23rd day of October, 2019

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

Original report signed by the inspector.