Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 27, 2020	2020_683126_0019	004743-20, 004865-20, 008126-20, 008131-20, 008624-20, 009779-20, 012549-20, 014646-20, 014848-20, 014976-20, 016060-20, 016138-20, 016871-20, 018529-20	Complaint

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

LINDA HARKINS (126), MANON NIGHBOR (755)

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): September 17, 18, 21, 22, 24, 25, 28, 29, 30, October 1, 2, 8, 9, 14, 15, 16, 2020 (off site) and October 5, 6, 7, 2020 (on site).

During this inspection the following logs were inspected:

Log #004743-20; Critical Incident (CI) #3013-000002-10, log #008624-20: CI #3013-000007-20, log #016060-20; CI #3013-000019-20 and log #, 018529-20; CI #3013-000023-20 related to an injury with a significant change in the resident's health status.
Log #009779-20; CI #3013-000010-20 related to an unexpected death
Log #014646-20; CI #3013-000016-20 related to missing narcotic/unaccounted
Log #014848-20; CI #3013-000017-20 and log #016138-20; CI #3013-000020-20 related to improper care /incompetent treatment of a resident
Log #014976-20; CI #3013-000018-20 allegation resident to resident abuse

Log #004865-20, complaint related to resident care and fall management
Log #008126-20, complaint related to nutritional care, bathing and discharge planning
Log #016871-20, complaint related to nutritional care and fall management

The following intakes were completed in the Critical Incident System Inspection:
Log #008131-20, (CI) # 3013-000005-10 and Log #012549-20, CI # 3013-000012-10 related to an injury with a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), the two Director of Care (DOCs), the Nurse Practionner (NP), the Occupational Therapist (OT), the Long-Term Care Coordinator, one Security Guard, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), several residents and several family members.

Reviewed resident health care records, reviewed the Fall Management Policy, Medication Administration policies, reviewed staffing schedules, critical incident reports and licensee internal investigation reports.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **2 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Medication 19 “Safe Medication Practices” and the MediSystem “Registre d’administration des stupéfiants et des médicaments contrôlés" policies, were complied with, for a specific resident.

O. Reg. 79/10 s.114 (2) requires that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, Registered Practical Nurse (RPN) #110, #130, #134 did not comply with those policies; “Safe Medication Practices” revised May 2019 and the MediSystem “Registre d’administration des stupéfiants et des médicaments contrôlés" revised January 17, 2017.

On a specific date in 2020, a Critical incident (CI) was submitted for 4 ampoules of narcotic/controlled substances missing/unaccounted for. The last documented dose of narcotic was administered to the resident three months prior.

On a specific date in 2020, one dose of the narcotic was administered by RPN #110. The RPN did not comply with the policies, that requires that the person who was administering the drug signed the Medication Administration Record (MAR) and the Narcotic and Controlled Drug Administration Record (NCDA).

On a specific date in 2020, two doses of narcotic were administered to the resident, one dose by RPN #130 and one dose by RPN #110. Both RPNS did not comply with the policy that requires that the person who is administering the drug signed the NCDA.

On a specific dated in 2020, RPN #134 documented on the NCDA that there were 10 ampoules of narcotics removed for destruction. Three out of ten doses were accounted for and were administered to the resident. As per the policy, the narcotic count should be done at the end of each shift with the assistance of another Registered Nursing staff.

Three months after the doses of narcotic were administered, RPN #130 noticed that there were 4 ampoules of narcotic missing/unaccounted. The policy requires that on a monthly basis, an RN with another registered nursing staff review the NCDA and report any discrepancy to the DOC. There was no monthly review for the resident NCDA for three months.

Sources: CI, LTCH's investigations notes, the resident's progress notes and MARS, Medications Administration Policies; interview with DOC #102 and other RPNs. [s. 8. (1) (b)]

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 medications policies are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that two staff members on one date and another two different staff members on a second date used safe transferring and positioning devices or techniques when assisting two residents.

On a specific date in 2020, one resident was transferred with a Sara lift instead or a ceiling lift. PSW's did not follow the resident's recommended transferring device indicated by the physiotherapist resident and their pictogram for a safe transfer resulted in resident sustaining injuries.

On a specific date in 2020, the other resident was transferred with a Sara lift instead or a mechanical lift. PSW's did not follow resident's recommended transferring device indicated by the physiotherapist resident and in their care plan for a safe transfer, resulted in resident sustaining injuries.

SOURCES : progress notes, care plan for both residents, The home's Lifts, Transfers and Repositioning Policy, revised 2014-08; interviews with Physiotherapist, RN #121, RPN #120 and PSW #118.

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Critical Incident (CI) written report include the outcome of a resident who was involved in the fall incident.

A CI was reviewed by Inspector #126 and it was noted that the fall incident occurred on a specific date in 2020 and resulted in an injury to the resident. The CI was amended five days later, indicating that the resident was admitted to the hospital. The CI was not amended to reflect the outcome post fall of that resident.

During the course of this inspection multiple CIs were reviewed and it was noted that several CIs did not include a final amendment for the outcome of the residents involved

in those incidents.

Discussion held with the Executive Director (ED) #100 and Director of Care (DOC) #102 related to ensure the amendment of the CIs as per requirements. They indicated that they will ensure that it is done in the future.

Sources: CI, the resident 's progress notes and interviews with DOC #102 and ED #100.

2. The licensee has failed to ensure that the Critical Incident (CI) written report include a analysis to prevent recurrence of staff for not reporting falls/incidents of two residents that resulted in injury for both of them.

The two CIs were reviewed for those residents and were submitted under an “incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident’s health status”. It was documented in the progress notes that each resident indicated they had a fall and assistance was provided by the staff to get them back to bed. The investigations were completed but they were unable to identify how the incidents occurred and which staff provided assistance.

Interviews with DOC #102 indicated they conducted both investigations and interviewed staff that worked during the specific time frame previous to the incident/fall. All staff denied seeing anything and no report was made related to those incidents/falls. Both incidents, resulted in an injury and it was unlikely that the residents would have been able to get back to bed on their own.

Interviews with several nursing staff (Registered Nurse (RN) #113, Registered Practical Nurse (RPN) #113, Personal Support Worker (PSW) #129) and they all indicated that they had nothing to report about these incidents and they were aware that they need to report any incident/fall.

Sources: The two CIs, the LTCH's investigation notes, two resident's progress notes and interviews with DOC #102 and other staff. [s. 107. (4) 4.]

Issued on this 4th day of November, 2020

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

Original report signed by the inspector.