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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 04, 2021	2021_831211_0008 (A1)	022462-20	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

Amended by JOELLE TAILLEFER (211) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

This licensee inspection report has been revised to reflect the changes made under:
-LTCHA, 2007 S.O. 2007, c.8, s. 6 (9) related to bathing,
-O. Reg. 79/10, s. 8 (1) and O. Reg. 79/10, s. 131 (2) related to typographical errors.

A copy of the amended report is attached.

Issued on this 4 th day of May, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by JOELLE TAILLEFER (211) - (A1)

Amended 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): On site March 11, 12, 15, 17, 18, 19, 22, 23, 24, 2021, April 19, 20, 2021, and offsite April 21, 22, 23, 2021.

This following complaint intake Log #022462-20 was completed related to the provision of resident care, alleged neglect, fall management, nutritional and hydration care, medication administration, skin and wound assessment, hospitalization and change of condition.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitian, Occupational Therapist, Physiotherapist, Coordinator and a family member.

Also, the inspector reviewed resident health care records, Fall Management, Medication Administration, Care Transitions-Admission, Transfer and Discharges LTC, Skin and Wound Care policies, review of the licensee internal investigation report and the licensee complaint documentation.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

4 WN(s)
4 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 :

(A1)
1. The licensee has failed to ensure that the care set out in the plan of care to record intake and output was provided to a resident as specified in the plan.

Review of the physician orders on an identified date indicated to record a resident's intake and output. Forty-two days later, the physician's order indicated to discontinue the intake and output monitoring.

The resident's intake and output monitoring sheets for three consecutive days were located in the resident's chart. A Registered Nursing staff stated that there was no additional intake and output monitoring sheets for the resident.

The licensee has failed to document the intake and output monitoring titled "Bruyere Feuille de Chevet des ingérés et excrétés" as prescribed in the physician orders for thirty-nine days.

Sources: Resident's "Bruyere Feuille de Chevet des ingérés et excrétés" sheets, chart. Interview with a Registered Nursing Staff. [s. 6. (7)]

2. The licensee has failed to ensure that a laboratory blood test set out in a resident's plan of care was provided to the resident as specified in the plan.

Review of the resident's progress notes indicated that the physician requested a follow-up to investigate the reason why the laboratory blood test ordered thirteen days ago was not performed.

Interview with a Registered Nursing Staff stated that the requisition was still in the laboratory binder tilted "Commis Laboratoire" behind the nursing station. Thus, the

resident's blood work requested by the physician was not drawn as ordered.

Sources: Resident's progress notes, orders written in the PCC under "order" tab, laboratory requisition, and interview with three Registered Nursing Staff and the ADOC. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in a resident's plan of care related bathing was documented.

Review of a resident's Point of Care (POC) under the section "Bath" for two months, doesn't have a section indicating to bath the resident on two specific days weekly as indicated on the "Bathing list Schedule" sheet placed on the wall inside the documentation room. The bathing documentation in the POC indicated that the resident received a bath twice for one month and once during the other month. The resident refused a bath twice during one of the two months.

Interview with the ADOC stated that the resident was receiving a bath twice a week, but the staff didn't document them apparently due to an electronic malfunction of the system in the POC.

The licensee has failed to ensure that the provision of the care set out for the resident was documented twice a week.

Sources: Resident's electronic health care records and interview with the ADOC. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the effectiveness of a resident's plan of care using the Dementia Observation System (DOS) was documented every shift.

The resident's progress notes written 13 days prior the resident discharged from the home indicated to start documenting the resident's behaviors using the DOS. The resident's Medication Administration Record (MAR) indicated to complete the DOS every shift and hourly.

The licensee has failed to ensure that the effectiveness of the resident's plan of care using the behaviors sheets (DOS) was adequately documented for 8 out of 14 days.

Sources: Resident's progress notes, the Medication Administration Record and the resident's Dementia Observational System (DOS). Interview with the ADOC. [s. 6. (9) 3.]

5. The licensee has failed to ensure that the effectiveness of a resident's plan of care related to the food and fluid intake monitoring was documented.

Review of the resident's electronic medical record in the progress notes and point of care under nutrition for meals was not documented for twenty days during supper times, 2 days during lunch times and one day during breakfast and lunch times within 2 months.

Sources: Resident's progress notes and point of care (POC) and interview with the Executive Director. [s. 6. (9) 3.]

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 care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that the provision of care set out in the plan of care and the effectiveness of the plan of care are documented, to be implemented voluntarily.

WN #2: 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 Fall Prevention policies and procedures included in the required Falls Preventions and Management Program were complied with, for a resident.

O. Reg. 79/10, s. 48. (1) requires an interdisciplinary falls prevention and management program to reduce the incident of falls and the risk of injury.

O. Reg. 79/10, s. 49. (1) requires the falls prevention and management program must, at a minimum, provide to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's policy and procedure "Fall Prevention, Long-Term Care" indicating that fall with potential head injury with or without anticoagulant use, the Registered Nurse (RN) completes and documents a clinical assessment of the resident, including a Neurological Assessment in Point Click Care (PCC), immediately.

Review of the progress notes written by a Registered Nursing Staff for two specific days indicated that the resident had unwitnessed falls. The physical assessment indicated that there was no injury.

Interview with a PSW stated that the resident was found on the floor with the head against the wall after a fall.

Interview with the ADOC stated that the resident's neurological assessment needed to be completed after the fall for both days since both falls were unwitnessed.

The licensee has failed to ensure to complete and document the neurological signs assessment as indicated in the Fall Prevention's policy.

Sources: Resident's health care records including the progress notes, post fall huddle, incident details forms. Review of the fall prevention policy and interview with a PSW and other staff. [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 where the Act or this Regulation requires the licensee of the long-term care home to have a policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's monthly weight monitoring system was measured and recorded.

Review of a resident's electronic health records and interview with a staff member indicated that the resident's weight was not completed for one of the months. The licensee has failed to record the resident's monthly weight for one of the months.

Sources: Resident's electronic health records in Point Click Care (PCC). Interview with a staff member. [s. 68. (2) (e) (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 a monthly weight monitoring system to measure and record with respect to each resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Review of a resident's care plan for several years indicated to administer the resident's medication as whole and not to crush the medication.

The medication administration records (MAR) indicated not to crush an identified extended release (ER) medication during the evening shift.

The resident's progress notes written on a specific day in 2020 by a Registered Nursing Staff indicated that the medications were crushed. Two months later, a meeting with the family indicated not to crush the resident's medication.

The MARs for four consecutive months indicated that another Registered Nursing Staff had administered the resident's medication on several evening shifts. Interview with the Registered Nursing Staff stated that once the resident's medication was crushed. Additionally, the Registered Nursing Staff stated they could not remember if the ER medication tablet was one of the medications crushed before being re-administered.

Sources: Resident's MAR, progress notes and current care plan. Interview with one of the Registered Nursing Staff. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 4 th day of May, 2021 (A1)

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

Original report signed by the inspector.