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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Modified 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
Feb 8, 2022	2021_831211_0021 (M1)	009505-21, 009661-21, 011043-21, 014105-21, 014213-21, 014543-21, 014817-21, 014853-21, 015977-21, 016867-21, 000768-22	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

Résidence Saint-Louis
879, chemin Parc Hiawatha, Ottawa ON K1C 2Z6

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

JOELLE TAILLEFER (211), JULIENNE NGONLOGA (502)

Amended Inspection Summary/Résumé de l'inspection modifié

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The public report was modified as grammatical errors were identified and corrected in the report.

Issued on this 8th day of February, 2022 (M1)

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

Original report signed by the inspector.

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879 Chemin Parc Hiawatha Ottawa ON K1C 2Z6

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

JOELLE TAILLEFER (211), 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): December 6, 7, 8, 9, 10, 14, 15, 16, 20, 2021 and January 21, 2022 (onsite) and December 17, 21, 22, 23, 2021,

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January 5, 6, 7, 11, 12, 2022 (offsite).

During this inspection the following logs were inspected:
-Log #000768-22 related to hospitalization and change in condition,
-Logs #014543-21 and #014817-21 related to medication incident and adverse drug reaction with a significant change in the resident's health status.
-Log #014105-21 related to allegation of neglect from staff to residents and Medication Administration,
-Log #015977-21 related to Infection Prevention and Control,
- log #016867-21 related to injury with unknown cause,
- log #011043-21 related to fall with injury,
- logs #014105-21, #014543-21 and 014817-21 related to medication administration,
- logs #009505-21, #009661-21 and #014213-21 related to fall with injury (bundled).

During the course of the inspection, the inspector(s) spoke with the Vice President, Residential and Community Care and Programs, Bruyère Continuing Care (VP), Director of Cares (DOCs), the Associate Administrator, Nurse Practitioner (NP), several Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Registered Dietitian (RD), a Pharmacist "Medisystem Pharmacy", Housekeeping Aides, Maintenance Aide, the Physiotherapist, Unit Support Workers (USWs), Active Screening Staff and several resident's family members and residents.

Also, the inspector reviewed several residents' health care records, including the electronic Point of Care (POC) documentation, reviewed several licensee's policies: "Gestion des incidents critiques: Residents, Soins de longue duree" #Gestion des Risques 04 SLD, "Medication in Long-Term Care: Transcription, Order verification, Receipt of" #Medication 06-02 LTC, "Safe Medication Practices" #Medication 19, "Incidents, Non-Critical: Patients, Residents, Visitor" #Risk Management 03, reviewed meeting summary with a staff member, emails sent by a family member related to Personal Protective Equipment, a letter sent by the licensee to a family member, email sent by the licensee to residents, family members and loved one related to suspect Covid-19 outbreak, email sent by the Assistant Administrator related a mandatory Infection Prevention and Control (IPAC) training and observed the residents' provision of care.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Pain
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **7 VPC(s)**
- **1 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. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies regarding medication administration are implemented in accordance with prevailing practices, for three residents.

Three residents have medications that were to be administered by a Registered Nursing Staff.

The licensee's policy titled "Safe Medication Practices" indicated that the patient takes medication in the presence of the regulated health professional and the regulated health professionals document all medication administered on the Medication Administration Record (MAR) or Flow Sheet immediately after administration.

Specifically, a Registered Nursing Staff did not comply with the licensee's policy and procedure "Safe Medication Practices" to document medications administered in residents' MARs after they were administered.

Review of a Meeting Summary indicated that several medications for three residents were signed by a Registered Nursing Staff as administered, but they were found in the medication cart, in their medication packages not administered by another Registered Nursing Staff working during another shift. The Meeting Summary indicated for the following residents:

1-A resident's Medication Administration Record (MAR) on a date in 2021, indicated that the resident's medications were signed as administered, but several medications prescribed to be administered for three different times were found in their medication packages not administered.

2-A second resident's Medication Administration Record (MAR) on two dates in 2021, indicated that the resident's medications were signed as administered but several medications prescribed to be administered at a certain time were found in their medication packages not administered.

3-A third resident's Medication Administration Record (MAR) on a date in 2021, indicated that the resident's medications were signed as administered but several medications prescribed to be administered at a certain time were found in their medication packages not administered. Moreover, the resident's MAR indicated that resident's vital signs were to be taken prior administering a medication. The medication prescribed daily were not to be administered if the systolic blood pressure (SBP) was less than a certain amount. The resident's blood pressure documented on the resident's MAR indicated that the resident's blood pressure was measured at two different times and the medication was to be administered as per the order. The medication was documented by the Registered Nursing Staff as administered on that date but found in the medication cart by another Registered Nursing Staff during another shift. Furthermore, there was another medication incident for another date in 2021, where the resident's medications were left at the resident's bedside. A DOC stated that several whole medications from a shift were found at the resident's bedside by another Registered Nursing Staff during the following shift. The medications were not administered as prescribed on that date in 2021, by a Registered Nursing Staff during a shift.

The DOC stated that the Registered Nursing Staff failed to administer the medication to three residents as indicated in the licensee's policy titled "Safe Medication Practices".

As such, there was actual risk for the three residents when their medications were not administered as prescribed potentially predisposing those residents to exacerbate their medical problems. Moreover, there was also actual risk when a resident's medications were left at the resident's bedside on a date in 2021.

Sources: Residents' health care records, licensee's policy titled "Safe Medication Practices" and interviews with several Registered Nursing Staff and a DOC. [s. 114. (3) (a)]

2. The licensee has failed to ensure that the written policy and procedure regarding medication processing and transcription were implemented in accordance with prevailing practices, for a resident.

Review of a resident's health care records indicated that the resident was known to have a brittle health condition. The resident's health care records revealed that a test level monitoring was not documented for two dates at an identified hour.

The resident's health care records' documentations indicated that the Nurse Practitioner (NP) ordered a monitoring test level at a specific time for one (1) week. The next day, the NP documented in the resident's progress notes that the test level monitoring was not verified and entered at the identified time. On that day, the NP ordered to monitor the test level at an identified time on an on-going basis to prevent a health condition. Five days later, the NP ordered to discontinue a medication order associated with the monitoring test level at the identified time. The next day, the NP documented in the resident's progress notes that the test level monitoring at the identified time was not taken as per order and the test monitoring was still active. Only the medication order at that identified time was discontinued.

Review of the resident's "Physician's DigiOrder" sheets revealed that staff members did not comply with the licensee's policy and procedure: "Medication in Long-Term Care: Transcription, order verification, receipt of" as followed:
-when the nurse transcribing the order on the "eMAR" did not initial the "1st check" box on the "Physican's DigiOrder" sheet on two dates in 2021, and
-when the "2nd check" box was not initialed by another nurse indicating that the order transcribed from the "Physican's DigiOrder" sheet into the eMAR by the pharmacy or another nurse was verified for four orders in 2021.

A DOC stated that the nurse who transcribed an order must initial the "1st check" box and a 2nd nurse who verified the transcribed order must initial the "2nd check" box on the Physician's DigiOrder sheet.

As such, since the process to transcribe and check an order in the "Physician's DigiOrder" sheets were not implemented as indicated in the licensee's policy and procedure, there was a potential risk of harm to the resident when the resident's test level monitoring was not verified by a Registered Nursing Staff on two dates at a specific time in 2021.

Sources: A resident's health care records and interview with a DOC. [s. 114. (3) (a)]

3. The licensee has failed to ensure that the written policies regarding medication

administration are implemented in accordance with prevailing practices, for a resident.

On a date in 2021, a resident was observed holding a container with a medication. A Staff member verified that the resident had the medication.

The resident's physician order showed that the medication was ordered as needed and that the resident could have the medication several times per day.

Review of licensee's policy titled "Medication in Long-Term Care: Transcription, Order Verification, Receipt of, stated that the regulated health professional documents all medication s/he has administered on the eMar or flow sheet immediately after administration, documenting the effects of all PRN medications.

Review of the eMar and progress notes for the identified date did not show that the medication was administered and the effects for the above medication was not documented.

The resident confirmed that they received the medication in the morning and afternoon. They will also get one in the evening and at bedtime.

The Staff stated that they should have signed the eMar prior to giving the medication to the resident.

Sources: Direct observation of the resident. Physician order, eMar, progress notes, Interviews with the resident and a staff. [s. 114. (3) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 written policy and procedure regarding medication processing and transcription were implemented in accordance with prevailing practices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents when a staff member was not wearing properly the Personal Protective Equipment (PPE).

On a date in 2021, the Vice President, Residential and Community Care and Programs responded to an email sent by a resident's family member who observed a Registered Nursing Staff not wearing a face shield and not properly wearing their face mask. The email indicated that the Registered Nursing Staff was wearing the masks pulled down completely under the chin.

At the date of the incident, the Chief Medical Officer of Health (CMOH) Directive #3 was still in effect indicating the following:
Universal Masking. All staff and visitors must always comply with universal masking and must wear a medical mask for the entire duration of their shift/visit. The following requirements apply regardless of whether the LTCH is in an outbreak or not.
Eye protection. All staff and essential visitors are required to wear appropriate eye protection (e.g., goggles or face shield) when they are within 2 metres of a resident(s) as part of provision of direct care and/or when they interact with a resident(s) in an indoor area.

The DOC and the Registered Nursing Staff acknowledged that the face shield and the masks were not properly worn on a date in 2021.

As such, residents were placed at risk for transmission of infection when the staff did not wear properly the PPE.

Sources: Resident's Health Care Records. Interviews with the DOC and the Registered Nursing Staff. [s. 5.]

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 home was a safe and secure environment for its residents when a staff member was not wearing properly the Personal Protective Equipment (PPE), to be implemented voluntarily.

WN #3: 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

Review of a resident's health care records indicated that the resident was known to have a brittle health condition.

The resident's POC under "Nutrition-Snack" on a date in 2021, indicated that a staff member did not document the snacks provided to the resident at 1030 hours.

Approximately four months later, the resident's health care records indicated that the resident started refusing nutritional and fluid intakes despite nourishment being offered. The resident's POC under "Nutrition-Snack" for two dates at 1030 hours and 1430 hours, and another date at 1430 hours, indicated that a staff member did not document the amount of the snacks consumed or if the snacks were refused. The resident's POC on a date at 1230 hours, indicated that a staff member did not document the amount of the lunch consumed or if the lunch was refused.

Staff members and a DOC stated that the snacks and the meals consumption should have been documented by a staff member.

As such, since several snacks and a lunch consumption were not documented, there was a potential risk in the management of the resident's health care treatment.

Sources: Resident's health care records and interviews two staff members and a DOC. [s. 6. (9)

2. The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised when the resident had an injury.

The progress notes showed that the resident was diagnosed with an injury and subsequently required an intervention. The physiotherapist (PT) assessment indicated that the resident was not able to bear weight prior and post-intervention.

The resident's written plan of care prior and post-intervention identified the resident as continent of bowel and bladder and required a specific device for transfer with two (2) person assists.

On a date, the resident requested assistance with toileting. A staff member transferred the resident to the toilet without assistance.

The staff member indicated that resident condition has improved, and they were able to use the toilet for their continence needs with one-person assistance using another transfer technique.

Three other staff members indicated that when the resident requests assistance for toileting, they transfer the resident using a specific transfer device to provide continence

care in bed.

Another staff member indicated that the resident was continent and was assisted in bed when the resident had urge for bowel or bladder, but continence care needs should be reassessed if the resident's needs have changed.

By not reassessing the resident continence care needs, the resident desire to use the toilet and stay continent was not promoted.

Sources: Direct observation, the resident's written plan of care, progress notes, staff interviews. [s. 6. (10) (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 that the resident is reassessed and the plan of care reviewed and revised at any other times when the resident's care needs change or care set out in the plan is no longer necessary, and to ensure that the following are documented:
1. The provision of the care set out in the plan of care,
2. The outcomes of the care set out in the plan of care,
3. The effectiveness of the plan of care, to be implemented voluntarily.

WN #4: 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 their medication management system policy was complied with when a medication incident for a resident was discovered on a date in 2021.

O.Reg. 79/10, s. 114. (3) requires that the licensee's written policies and protocols must be implemented, evaluated, and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Specifically, staff did not comply with the licensee's policy titled "Incident, Non-Critical Patients, Residents, Visitors" policies that indicated under Reporting and Documentation:
-The appropriate health-care professional documents the fact related to the incident in the patient record, including information such as the nature of the incident, interventions, and persons notified.
-The appropriate health-care professional completes the online "Risk Incident Management System (RIMS) within the same shift.
-The manager, director of care or their delegate:
• Review the RIMS report within 24 hours,
• Begin an investigation within 48 hours of the incident, following up as appropriate and ensuring that the physician has been notified of patient-related incident, and changes the RIMS report status to "investigating",
• Completes the investigation withing 10 days of the incident and changes the RIMS report to "closed".

Review of the resident's Medication Administration Record (MAR) indicated that several prescribed medications were signed as administered by a Registered Nursing Staff on a date in 2021.

A Registered Nursing Staff stated that several medications from the previous shift were found at the resident's bedside by an identified person. The medications were given to a Registered Nurse during that shift. The Registered Nurse stated that the medications discovered on the identified date were placed in an envelope in the DOC's office six days later.

The DOC validated that the medications incident should have been reported and a written Risk Management System (RIMS) completed immediately when the resident's medications were discovered at the resident's bedside on the identified date in 2021 as

per the policy titled "Incident, Non-Critical Patients, Residents, Visitors". The DOC stated that the RIMS was completed seven (7) days later and the RN was informed when any medication incidents are discovered, a RIMS must be completed on the same shift.

As such, there was actual risk for residents when the steps defined above in the licensee's policy titled "Incident, Non-Critical Patients, Residents, Visitors" were not followed when the resident's medications were discovered not to be administered on an identified date in 2021. Consequently, further medications for several residents were not administered by the Registered Nursing Staff that were discovered six days later.

Sources: Resident's health care records and interviews with several Registered Nursing Staff and a DOC. [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 a long-term care home to have, institute or otherwise put in place any policy and procedure, the licensee is required to ensure that the policy and procedure is complied with, to be implemented voluntarily.

WN #5: 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 staff use safe transferring and positioning devices or techniques when assisting a resident.

The progress notes showed that a resident was diagnosed with an injury and subsequently required an intervention.

The resident's plan of care and the pictogram above the resident's bed showed that the resident required an identified device with two-person assistance for all transfers.

On a date in 2021, the resident requested assistance with toileting. A staff member transferred the resident to the toilet without assistance of another staff.

The staff member stated that the resident needed two-person transfer from bed to wheelchair and one-person assist from wheelchair to toilet, because the resident range of motion (ROM) had improved since the intervention. The staff member indicated that they were able to transfer the resident to toilet with one-person assistance using pivot technique.

Physiotherapist stated that the resident required two-person assistance for all transfers. They had not received a referral to assess the resident's transfer needs.

The staff used a transfer method that was not approved by the physiotherapist, which put the resident at risk of another injury.

Sources: Direct observation, a resident's progress notes, plan of care, physiotherapy assessment, pictogram, staff interviews. [s. 36.]

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 #6: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident administers a medication to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

A resident was observed holding a container with a medication, while ambulating independently into their room after a meal service.

Inspector #502 brought that to a staff's attention. The staff verified that the resident had the medication.

The resident's physician order indicated to administer the medication as needed and that the resident could have the medication several times per day, but the record did not identify that the resident could self-administer the ordered medication by the prescriber.

Review of licensee's policy titled "Medication in Long-Term Care: Transcription, Order Verification, Receipt of", stated that "the patient take medication in the presence of the regulated health professional, unless he/she is enrolled in the Self-medication Program, or there is a Physician's order on the chart allowing the patient to keep a medication(s) at their bedside for self-administration.

The resident stated that the staff member gave them the medication after meal to take to their room, so they can self-administer the medication when they need it.

The staff member acknowledged giving one tablet of the medication to the resident after their meal to self-administer as the resident was cognitive and capable of administered the medication themselves.

Another staff member verified that the resident did not have an order from the physician to self-administer the above identified medication.

The staff member did not observe the resident take the medication, as such the medication could have been taken by another resident.

Sources: Direct observation of the resident. Physician order, eMar, licensee's policy. Interviews with the resident and two staff members. [s. 131. (5)]

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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program as it relates to the Hand Hygiene (HH) Program in accordance with the Ontario evidence based HH program, "Just Clean Your Hands (JCYH)".

During a meal service on an identified unit, the inspector observed two residents assisted by staff into the dining room and were served lunch without hand hygiene being performed. Another resident ambulated independently into the dining and was served lunch without performing hand hygiene.

Two staff members indicated that they assisted with the transportation of the resident from their room to the dining room. The staff members indicated that they were not responsible for the residents' hand hygiene, and they did not observe them perform any form of hand hygiene prior to their meals being served.

Another staff member stated that they did not assist residents perform hand hygiene. They further indicated that bottle of "Purell" hand sanitizer that were placed on dining room tables for residents' hand hygiene, has been removed for residents' safety.

Another staff member stated that they did not assist a resident perform hand hygiene as the resident was capable to perform hand hygiene without staff assistance and alcohol-based hand sanitizers were readily accessible in hallways and in the dining room.

During an interview with Inspector #211, a resident verified that they did not perform hand hygiene, staff did not assist them and did not remind them to perform hand hygiene.

As such, there was a potential risk to residents of being impacted by cross-contamination if their hands were unclean.

Sources: Direct observations: for three residents, three staff members. Review of The Hand Hygiene (HH) Program in accordance with the Ontario evidence based HH program, "Just Clean Your Hands (JCYH)" and resident and staff interviews. [s. 229. (4)]

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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident exhibiting altered skin integrity has been assessed by a registered dietitian who is a member of the staff of the home, and have any changes made to the plan of care related to nutrition andhydration been implemented.

On a date in 2021, a skin injury was observed on a resident's body area and another altered skin integrity on another body area.

The resident's progress notes showed that the resident had an altered skin integrity on two different body areas four months ago. Three months later, staff noted a skin injury on another area of the resident's body. One month later, staff noted a skin injury on the resident's body area, and another altered skin integrity to another body area. Four days later, a registered nursing staff noted another skin injury on a different body area and altered skin integrity to another body area.

The skin assessment record did not identify skin assessment completed by the in-house registered dietitian for the above identified skin injuries.

A staff member stated that the current process directs nursing staff to complete dietary referral for wound and not for other altered skin integrity issues. The Staff confirmed that they had not completed skin assessment for the identified altered skin integrity issues. [s. 50. (2) (b) (iii)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Registered nursing staff documented on a date in 2021, that the resident told staff they were having severe pain in an area of their body. The RPN massaged the affected area and administered an analgesic. The pain was temporary relieved.

The next day, registered nursing staff documented that the resident was unable to stand during care. The resident appeared to be in severe discomfort while pointing along the area of their body. The resident expressed severe pain when staff attempted to mobilize an area of the body. The PT documented that resident was not able to bear weight. Staff notified the physician who directed them to transfer the resident to hospital. The next day, the resident was diagnosed with an injury.

The pain assessment record did not identify a completed pain assessment when the initial pain worsened on the next shift.

VP in consultation with DOC indicated via email that pain assessment was not completed as the pain was relieved with initial interventions. This did not support the fact that the resident pain worsened during the next day shift and the resident was transferred to the hospital related to the same pain.

Source: the resident's progress note, pain assessment record, VP's email and staff interviews. [s. 52. (2)]

Issued on this 9th day of February, 2022

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOELLE TAILLEFER (211), JULIENNE NGONLOGA (502)
Inspection No. / No de l'inspection :	2021_831211_0021
Log No. / No de registre :	009505-21, 009661-21, 011043-21, 014105-21, 014213-21, 014543-21, 014817-21, 014853-21, 015977-21, 016867-21, 000768-22
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 8, 2022
Licensee / Titulaire de permis :	Bruyère Continuing Care Inc. 43 Bruyère Street, Ottawa, ON, K1N-5C8
LTC Home / Foyer de SLD :	Residence Saint-Louis 879 Chemin Parc Hiawatha, Ottawa, ON, K1C-2Z6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Melissa Donskov

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Bruyère Continuing Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 114 (3) (a)
The licensee shall:
1. Ensure that all registered nursing staff of the long-term care (LTC) home are re-educated on the licensee's policies related to the administration of medication documentation.
2. Conduct weekly audits for four (4) consecutive weeks to assess compliance with the licensee's written policies and protocols in relation to the administration of medication documentation.
3. Document, implement and re-evaluate corrective actions to address any identified deficiencies while ensuring that lessons learned are incorporated into the quality improvement processes.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policies regarding medication administration are implemented in accordance with prevailing practices, for three residents.

Three residents have medications that were to be administered by a Registered Nursing Staff.

The licensee's policy titled "Safe Medication Practices" indicated that the patient takes medication in the presence of the regulated health professional and the

regulated health professionals document all medication administered on the Medication Administration Record (MAR) or Flow Sheet immediately after administration.

Specifically, a Registered Nursing Staff did not comply with the licensee's policy and procedure "Safe Medication Practices" to document medications administered in residents' MARs after they were administered.

Review of a Meeting Summary indicated that several medications for three residents were signed by a Registered Nursing Staff as administered, but they were found in the medication cart, in their medication packages not administered by another Registered Nursing Staff working during another shift. The Meeting Summary indicated for the following residents:

1-A resident's Medication Administration Record (MAR) on a date in 2021, indicated that the resident's medications were signed as administered, but several medications prescribed to be administered for three different times were found in their medication packages not administered.

2-A second resident's Medication Administration Record (MAR) on two dates in 2021, indicated that the resident's medications were signed as administered but several medications prescribed to be administered at a certain time were found in their medication packages not administered.

3-A third resident's Medication Administration Record (MAR) on a date in 2021, indicated that the resident's medications were signed as administered but several medications prescribed to be administered at a certain time were found in their medication packages not administered. Moreover, the resident's MAR indicated that resident's vital signs were to be taken prior administering a medication. The medication prescribed daily were not to be administered if the systolic blood pressure (SBP) was less than a certain amount. The resident's blood pressure documented on the resident's MAR indicated that the resident's blood pressure was measured at two different times and the medication was to be administered as per the order. The medication was documented by the Registered Nursing Staff as administered on that date but found in the medication cart by another Registered Nursing Staff during another shift. Furthermore, there was another medication incident for another date in 2021,

where the resident's medications were left at the resident's bedside. A DOC stated that several whole medications from a shift were found at the resident's bedside by another Registered Nursing Staff during the following shift. The medications were not administered as prescribed on that date in 2021, by a Registered Nursing Staff during a shift.

The DOC stated that the Registered Nursing Staff failed to administer the medication to three residents as indicated in the licensee's policy titled "Safe Medication Practices".

As such, there was actual risk for the three residents when their medications were not administered as prescribed potentially predisposing those residents to exacerbate their medical problems. Moreover, there was also actual risk when a resident's medications were left at the resident's bedside on a date in 2021.

Sources: Residents' health care records, licensee's policy titled "Safe Medication Practices" and interviews with several Registered Nursing Staff and a DOC. (211)

2. The licensee has failed to ensure that the written policies regarding medication administration are implemented in accordance with prevailing practices, for a resident.

On a date in 2021, a resident was observed holding a container with a medication. A Staff member verified that the resident had the medication.

The resident's physician order showed that the medication was ordered as needed and that the resident could have the medication several times per day.

Review of licensee's policy titled "Medication in Long-Term Care: Transcription, Order Verification, Receipt of, stated that the regulated health professional documents all medication s/he has administered on the eMar or flow sheet immediately after administration, documenting the effects of all PRN medications.

Review of the eMar and progress notes for the identified date did not show that the medication was administered and the effects for the above medication was

not documented.

The resident confirmed that they received the medication in the morning and afternoon. They will also get one in the evening and at bedtime.

The Staff stated that they should have signed the eMar prior to giving the medication to the resident.

Sources: Direct observation of the resident. Physician order, eMar, progress notes, Interviews with the resident and a staff.

An order was made by taking the following factors into account:
Severity: Three (3) residents' MAR indicated that several medications were signed as administered by a Registered Nursing Staff for several dates within seven days in 2021, but they were found not administered and another resident's medication was administered but not signed by a Registered Nursing Staff on a date in 2021. Consequently, two Registered Nursing Staff did not comply with the licensee's policies to document medications administered in residents' MARs after they were administered.
Scope: This non-compliance is widespread because as it affects four (4) identified residents.
Compliance History: There was voluntary plan of correction (VPC) issued on October 2021 under a different subsection of the regulation O.Reg. s. 8. (1) (b) and on April 2021 under subsection of the regulation O.Reg. s. 131 (2), both related to medication administration in the past 36 months. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of February, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joelle Taillefer

Service Area Office /
Bureau régional de services : Ottawa Service Area Office