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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jan 31, 2022	2021_818502_0005	005871-21, 013847-21, 013853-21, 016205-21, 018997-21	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

JULIENNE NGONLOGA (502), JOELLE TAILLEFER (211)

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): December 6, 7, 8, 9, 10, 15, 2021. December 13, 17, 2021 (offsite)

During this inspection the following intakes were inspected:
log #: 005871-21, (CIS #3013-000009-21), related to allegation of staff to resident abuse,
log # 013847-21, related to fall with a significant change in the resident's health status.,
log #016205-21 related to restraint, and
log #013853-21 (3013-000021-21) and log #018997-21 related to multiple care concerns,
log #018997-21 related to allegation of neglect pertaining to the provision of resident's care.

During the course of the inspection, the inspector(s) spoke with the Vice President, Residential and Community Care and Programs, Bruyère Continuing Care (VP), (VP), Directors Of Care (DOCs), Nurse Practitioner, several Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), unit Support Workers (USWs), Screening Staff, a Maintenance Aide, the Physiotherapist, one housekeeper, Associate Administrator, resident' family members and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 there was a written plan of care that sets out, clear directions to staff and others for a resident's continence care and another resident's sleep patterns.

A resident's care plan indicated that the resident required extensive assistance from one staff member for toileting. The resident was bladder incontinent, but bowel continent. A Registered Nursing Staff stated that the resident was wearing one kind of continent product during the night and a different kind of continent product during the day.

On a date in 2021, the Registered Nursing Staff showed Inspector #211 that there were two different kinds of continent products inside the resident's cupboard. However, therewas no signage put inside the door of the resident's cupboard regarding the type of continence product used by the resident.

The Registered Nursing Staff acknowledged that the resident's care plan did not indicate the kind, the size and the frequency the resident's incontinent product needed to be changed. Furthermore, there was no signage inside the resident's cupboard door related to resident's continent products.

Thus, since the resident's plan of care did not set out, clear directions to staff and others related to the resident's continence care, there was a potential risk that the resident was not provided with continence care and/or sufficient changed to remain clean, dry and comfortable.

Sources: Resident's health care records and interview with a Registered Nursing Staff. [s. 6. (1) (c)]

2. A resident's care plan initiated on a date in 2021, indicated under sleep patterns that the resident prefers to get up at 0830 hours.

On a date in 2021 at 1026 hours, Inspector #211 observed the resident sitting in the dining room wearing a night clothes. A staff member stated that the resident was still wearing a nightgown because the resident just woke-up. The staff members must wait until the resident wakes-up by themself before providing morning care.

A Registered Nursing Staff acknowledged that the resident's plan of care should indicate that the resident preferred to wake-up by themself prior receiving their breakfast and getting dressed for the day.

Thus, there a potential risk that the resident's sleep pattern was not respected according to the resident's wishes.

Sources: Resident's health care records and interviews with two staff members. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborate with each other, in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

On a date in 2021, a resident was found restrained in bed. The home's investigation notes indicated that after dinner, the resident exhibited identified responsive

behaviours. Two staff transferred the resident to bed. The resident continued to exhibit the same responsive behaviours while attempting to get out of bed. One staff restrained the resident to prevent them from falling.

The resident's Substitute Decision Maker (SDM) stated staff should have followed the strategy communicated to one identified staff that involved the resident's spouse, as this was identified as preventing evening responsive behaviours. The identified staff had implemented this strategy three times with effect before this incident.

The identified staff confirmed the SDM's statement and indicated that they did not communicate the strategy to other team members before leaving for their break the day of the incident.

Both staff who transferred the resident to bed, stated that they were not aware of the above strategy.

DOC verified that the identified staff did not communicate the strategy to other team members orbrought it to the charge nurse's attention.

By not collaborating with each other, the resident was transferred to bed instead of being by the phone, which increase their identified behaviours and resulted in the resident being restrained.

Source: Home's investigation notes, a resident's progress notes, and care plans; interviews with resident's POA, three staff interviews and DOC. [s. 6. (4) (b)]

4. The licensee has failed to ensure that the provision, the outcomes, and the effectiveness of the care set out in the plan of care were documented related to bathing, mouth care and continence care.

Three residents' health care records indicated that the residents required staff assistance with bathing, mouth care and continence care.

Review of the residents' health care records and the point of care (POC) indicated that the residents' provision of care related to bathing, mouth care and continence care were not documented for the following dates:

A) Bathing
First resident's POC showed that the staff member did not document for a week in 2021, that the resident was bathed twice a week.
Second resident's POC showed that the staff member documented that the resident was

bathed once for a week in 2021. The staff member did not document for the following week in 2021, that the resident was bathed twice a week.

B) Oral Care
Review of three residents' POC indicated that the staff member did not document the provision of mouth care for several days and shifts in 2021 as followed:
- First resident for twelve (12) days during the evening shifts, and six (6) days during the day and the evening shifts.
- Second resident for fourteen (14) days during the day and evening shifts, and ten (10)days during the evening shifts.
- Third resident for twenty-six (26) days.

C) Continence Care
Review of three residents' POC indicated that the staff member did not document the provision of continence care for several days and shifts in 2021 as followed:
- First resident for five (5) days during the evening and night shifts, 2 days during the evening shifts, one (1) day during the night shift and one (1) day during a day shift.
- Second resident's plan of care indicated to check and provide toileting before and after meals and at bedtime. The provision of continent care was not documented for several days in 2021 on the following shifts: three (3) days during the evening and night shifts, three (3) days during the night shifts, two (2) days during the day shifts and one (1) day during an evening shift.
- Third resident's plan of care indicated to check and provide toileting before and after meals and at bedtime. The provision of continent care was not documented for several days in 2021 on the following shifts: nine (9) days for the night shifts, two days for the evening shifts, three days (3) days for the evening and the night shifts, one day for a day shift and one (1) day for all three shifts.

On a date in 2021 at 1015 hours, a resident was observed not properly groomed and clothed. The staff members stated that the residents' personal hygiene was provided every day but some of the residents' care were provided later during the morning because they needed two staff members assistance. They validated that the residents' hygiene care was not always documented when the care was provided or refused in the resident's health care records.

A DOC confirmed that the staff members were providing the residents' personal care,but they were not always documenting them in the resident's health care records.
As such, since the residents' bathing, mouth care, and continence care were not documented for the above amount of days and shifts, there was potential risks that the residents' personal hygiene care may not have been provided.

Sources: Residents' health care records and interviews with staff members and a DOC. [s. 6. (9)]

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 ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was not restrained by the use of a physical device, other than in accordance with section 31 (included in the resident's plan or care) or under the common law duty described in section 36.

On a date in 2021, a resident was lying in bed, restrained with an identified physical device. The resident was verbally responsive as they were not able to move or call for assistance, injury was not noted.

Review of the home's investigation notes showed that a staff transferred the resident to bed, the resident displayed identified behaviours and did not want to stay in the bed. The staff requested assistance from another staff. The second staff used the identified physical devise to prevent the resident of getting out of the bed.

The resident's chart did not identify a physician order or a family's consent for the useof restraint.

The resident's spouse stated that they were not able to reach the resident as agreed on the phone at bedtime. They came to the home to check on the resident and found the resident restrained with the identified physical devise. They did not consent to any restrain.

Both staff stated that the resident was at high risk for fall. After diner, the resident displayed identified behaviours. The resident was transferred to bed but continued the same behaviours. The second staff restrained the resident with the identified physical devise to prevent the resident from getting out of the bed. They acknowledgedthat the resident could not move or access the call bell for assistance.

DOC verified that the resident was restrained by an identified physical devise that was not ordered by a physician. They indicated that staff should have called the charged nurse for assistance when they felt overwhelmed.

Source: CIS #3013-000029-21, home's investigation notes, a resident's progress notes, and care plans; interviews with a resident, two staff and a DOC. [s.30. (1) 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 ensure that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #3: 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 when a resident exhibited altered skin integrity, the resident received:
(i) 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) immediate treatment and interventions to promote healing.

On a date in 2021, Inspector #211 observed several skin integrity injuries. The resident stated that these injuries has been present for a long time.

The resident's progress notes, approximately two weeks and a half prior to this Inspection, did not identify documentation related to the resident's skin integrity injuries of unknown origin, this was brought to the home's attention. The Nurse Practitioner (NP) assessed the resident's injuries using the clinically appropriate assessment instrument designed for skin and wound. The NP documented that the size and the location of each resident's injuries and noted that the resident was administered the specified medication, which is known to increase risk of altered skin integrity.

Review of the resident's Medication Administrator Records (MAR) for identified period of two months indicated that the resident was being administered a specified medication twice a day.

Two Registered Nursing Staff validated that the resident's injuries were not assessed on two occasions within a period of two weeks, using the clinically appropriate assessment instrument designed for skin and wound.

As such, there was actual risk when the resident was not assessed with a clinically appropriate assessment instrument designed for skin and wound assessment, and the treatment and interventions were not provided to the resident to promote healing for a period of two and a half weeks.

Sources: The resident's health care records. Interviews with Registered Nursing Staff and the Nurse Practitioner. [s. 50. (2) (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 when a resident exhibiting altered skin integrity, including skin breakdown receives:
(i) 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, and (ii) immediate treatment and interventions to promote healing, to be implemented voluntarily.

Issued on this 10th day of February, 2022

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

Original report signed by the inspector.