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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date November 9, 2022
Inspection Number 2022_1508_0002
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Bruyère Continuing Care Inc

Long-Term Care Home and City
Residence St Louis, Ottawa

Lead Inspector
Manon Nighbor #755

Inspector Digital Signature
Manon Nighbor Digitally signed by Manon Nighbor Date: 2022.11.15 15:12:32 -05'00'

Additional Inspector(s)
Julienne Ngo Nloga # 502
Laurie Marshall #742466 was present during this inspection

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 15-17, 20, 22-24, 27-30, July 6-8, 18-22, 25-28, 2022.

The following intake(s) were inspected:
-Intake #005483-22 related to transfers, falls, pain management, medication, personal care and skin care.

NOTE: A Compliance Order related to O. Reg 246/22 s. 54(1) identified in a concurrent inspection #2022_1508_0001 (Log # 009638-22) was issued in this report.

The following **Inspection Protocols** were used during this inspection:
• Continence Care
• Falls Prevention and Management
• Medication Management
• Pain Management
• Resident Care and Support Services
• Skin and Wound Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6(9)1.
The licensee has failed to ensure that the provision of care related to bathing, continence care and skin monitoring, set out for resident's plan of care, were documented.

Rational and Summary
A) The resident's plan of care required the resident to have assistance for their bathing. In a period of four months, there were numerous incidents where the bathing care provided was not documented or if the resident refused to receive their baths.

A personal Support Worker (PSW) confirmed that they provided the resident their bath and sometimes the resident refused to have their bath, they said they must have forgotten to document. A second PSW stated they provided the care and forgot to document. A third PSW indicated that they recalled providing the resident a bath with their colleague and thought their colleague was going to document.

B) The resident's plan of care stated that the resident was incontinent and wore incontinence products. The resident required assistance for their continence care. It was also indicated to change their continence care product at specific intervals and as needed if soiled.
There were multiple shifts in a period of two months, where there were no documentation indicating the continence care was provided or refused.

As per two staff members the care provided or refused is expected to be documented.

C) The resident developed skin breakdown and a treatment cream was prescribed and administered. The resident's plan of care indicated the resident required skin monitoring every shift.
There were numerous shifts where there was no documentation of the resident's skin monitoring in a period of a month.

Two staff members explained that the resident had skin breakdown which had healed but remained at risk of potential skin breakdown. A registered practical nurse (RPN) and a registered nurse (RN) shared that it was difficult to provide care to the resident. The resident would decline care at times. The refusal of care was not documented.

There was a moderate risk to the resident since the care provided or refused was not documented. It was difficult to monitor and assess the resident's care and responses to care.

Sources:
Electronic health care record including point of care, plan of care and progress notes, skin and wound assessments
Interviews with five staff members. [755]

WRITTEN NOTIFICATION MEDICATION MANAGEMENT SYSTEM

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 114 (3) (a)
The licensee has failed to comply with their Safe Medication Practices policy medication administration documentation.

In accordance with O Reg 79/10 s 8 (1) (b) the licensee is required to ensure that their Safe Medication Practices policy is complied with.

Specifically, staff did not comply with the home's MEDICATION 19, Safe Medication Practices policy, related to the resident.

Rational and Summary
The resident was prescribed a medication as needed. An RPN documented in the medication administration record (MAR), the administration of a medication to the resident and did not administer the medication to the resident.

The licensee's Safe Medication Practices policy states that the regulated health professional documents all medication s/he has administered on the MAR or Flow Sheet immediately after administration, documenting the effects of all PRN medications.

In an interview the RPN nurse stated that they did not administer the medication to the resident since the resident did not require it. Another staff member, confirmed that the audit for this resident's medication, remained unchanged. The medication documented was not administered.

Sources:
Interview with two staff members.
MEDICATION 19, Safe Medication Practices policy, effective 2009-07, revised 2019- 05, issued 2015-12 and revised 2021-05.
Electronic health care record including progress notes, MAR, resident's medication audit form. [755]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 55 (2) (b) (iv)
The licensee has failed to ensure that the resident's skin breakdowns were reassessed at least weekly by a member of the registered nursing staff, as clinically indicated.

Rational and Summary
During the period of a month the resident was experiencing skin breakdown. A weekly skin and wound assessment tool was initiated. The skin and wound assessment indicated that the resident had two wounds in different specific areas.

The RPN initialized the MAR indicating they had completed a skin and wound assessment tool but did not complete the skin and wound assessment tool that day.

Another RPN confirmed that the skin and wound assessment tools were completed electronically, and they demonstrated the list of the skin and wound assessments completed, during that period of time. There was a week where there were no skin and wound assessment completed.

Sources:
Interview with two staff members.
Electronic health care record including progress notes, MAR, skin and wound assessment tools. [755]

COMPLIANCE ORDER [CO#01] [LEGISLATIVE SECTION TITLE]

NC#04 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 54. (1)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]
The Licensee has failed to comply with O. Reg. 246/22 s. 54 (1) The licensee shall: A. Educate registered staff who worked on a specific unit during a certain period of time on the fall prevention policy, specifically the post unwitnessed fall procedure. B. Document the education, including the content of the education, the staff member who provided the education, date, and the names of staff who participated in the education. C. Perform two audits (by weekly) over a period of four weeks to ensure the completion of the post unwitnessed fall neurological assessments documentation when indicated. D. Document the audits and actions taken based on the audit results.

Grounds
Non-compliance with: O. Reg. 246/22 s. 54 (1) The licensee has failed to comply with their post falls prevention policy and procedure for the monitoring of two residents. In accordance with O. Reg. 246/22 s. 11. (1) (b) the licensee is required to ensure that their falls prevention policy, procedure is complied. Specifically, staff did not comply with the home's Fall Prevention in Long Term Care policy and procedure, related to residents unwitnessed falls, neurological assessments. **Rational and summary** As per the licensee's fall prevention policy, neurological signs must be initiated following an unwitnessed fall. The policy states that the neurological assessment post unwitnessed fall must be conducted initially after the fall, 30 minutes after the initial assessment and every shift following, for 48 hours.

A review of the progress notes, post falls huddles and neurological assessments indicated there were several neurological assessments that were not completed as per the home's fall prevention policy and procedure for two resident's unwitnessed falls.

For a period of three months, one of the residents had multiple unwitnessed falls and numerous neurological assessments were not completed.

For a period of approximately six weeks, a second resident had multiple unwitnessed falls and several neurological assessments were also not completed.

Two staff members, confirmed that the unwitnessed post falls neurological assessments for the residents were not completed as per the licensee's policy frequency. Not completing the residents' neurological assessments could potentially place the residents at risk since staff would not be able to monitor if they developed post falls changes in their health status.

Sources:
Two staff members.
Fall Prevention Policy CLIN CARE 33 LTC-issued 2015-12 and revised 2021-05.
Electronic health care record including progress notes, post fall huddles and neurological assessments. [755]

This order must be complied with by December 23, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
email: MLTC.AppealsCoordinator@ontario.ca

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