Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: April 12, 2023

Inspection Number: 2023-1508-0003

Inspection Type:
Follow up
Critical Incident System

Licensee: Bruyere Continuing Care Inc.

Long Term Care Home and City: Residence Saint-Louis, Ottawa

Lead Inspector	**Inspector Digital Signature**
Joelle Taillefer (211)	Joelle Taillefer Digitally signed by Joelle Taillefer Date: 2023.04.14 14:48:38 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following date(s): January 26, 30, 31, 2023, February 1-3, 7-9, 14, 15, 21-24, 2023.

The following intake was completed in this complaint inspection:
• Intake: #00002353: complaint was related to an elevator that has been out of service.

The following intake(s) were completed in this Critical Incident (CI) inspection:
• Intake: #00005587, #00011606, #00011881, #00012824 were related to falls prevention and management,
• Intake: #00019306 was related to follow-up order LTCHA, 2007 s. 6 (10) (b) from inspection 2022_1508_0001(A2),
• Intake: #00018347 was related to follow-up order O. Reg. 246/22 - s. 54 (1), from inspection #2022_1508_0002,
• Intake: #00017410 was related to reporting and complaint,
• Intake: #00018622 was related to reporting and complaint, skin and wound prevention and management, and allegation of abuse,
• Intakes: #00019100, #00017547 were related to allegation of abuse.

Previously Issued Compliance Order(s)

The previously issued compliance orders related to LTCHA, 2007 s. 6 (10)(b) from inspection #2022_1508_0001(A2) and O. Reg. 246/22 s. 54 (1), from inspection #2022_1508_0002, were found to be in compliance by Joelle Taillefer [211].

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Personal Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 36

The licensee has failed to ensure that a resident received individualized personal care when the staff members were not responding to the resident care needs by not responding to the call bell in a timely manner.

Rational and Summary:

On a date, the Office Unit Clerk received information from a resident's family member that the resident-staff communication and response system was not functional and/or accessible for the resident for 3 continuous dates. The resident-staff communication and response system were tested, and the system was functioning properly. The family member stated that it was identified and communicated to ensure

the resident had the call button accessible and the resident did not receive care on an identified date while a family member was present.

The resident's call bell placed by the resident and responses (defined as cancelled hereunder) as per the response system report sheets were reviewed randomly by Inspector #211 for the following dates:
-On an identified date, call placed during:
· The day shift at specific hours was cancelled 1 hour and 2 minutes later, 56 minutes later, and 26 minutes later.
· The evening shift at a specific hour was cancelled 57 minutes later,
-One day later, call placed during:
· The day shift at an identified hour was cancelled 54 minutes later,
· The evening shift at an identified hours was cancelled 2 hours and 49 minutes later,
-Five days later, call placed during:
· The day shift at an identified hour was cancelled 34 minutes later,
· The evening shift at an identified hour was cancelled 39 minutes later,
-Seventeen days later, call placed during:
· The day shift was cancelled 2 hours and 9 minutes later.

Accordingly, it took an average of over 1 hour to cancel 6 identified calls within 58 calls placed within 3 identified dates.

The resident's Medication Administration Record from a month on an identified day, indicated to ensure that the call bell was working at the beginning of each shift at 0700 hours, 1500 hours, and 2300 hours.

The call bell was documented by the Registered Nursing staff as working on an identified day, at a specified time. The MAR indicated that the resident was administered medication at a specified time. However, the response system report sheets indicated that the call bell remained un-answered during which time medication had been administered.

The Administrator stated that there may have had a technology problem with the call bell placed on two identified dates which took over 2 hours to cancel the call at the point of activation in the resident's room. The Administrator showed that on an identified date, a Registered Nursing Staff was noted to have administered the resident their medication when the call bell was noted to be active but did not know why the call bell was not cancelled over 2 hours. The Administrator stated that the staff members may take longer to respond to the resident when they are assisting other residents during mealtimes. The Administrator was unable to provide a clear explanation as to the reason why it took over 1 hour to cancel the resident-staff communication and response system at the point of activation after the call bell had been activated in the resident's room for three different dates.

As such, the resident was at risk of not receiving individualized personal care needs in a timely manner when it took over 1 to 2 hours for the staff members to cancel the resident-staff communication and response system at the point of activation after the resident's call bell was activated.

Sources: Resident's health care records, communication and response system report sheets and interview with a Registered Nursing Staff and the Administrator. [211]

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 set out in the plan of care related to hourly rounding monitoring checks and bladder and bowel care were documented.

Rationale and Summary:

A resident's care plan on a date in 2022, indicated that the resident was identified as a high risk for falls. The resident was unable to mobilize and was transferred with a specific device.

The resident's plan of care did not indicate the reason as to why the resident needed a rounding check.

1.The "Documentation Report" tasks, within forty-four days, indicated that there were no documentation related to the hourly rounding monitoring checks under "Focus Rounding" tasks for fifteen day shifts, twenty-six evening shifts, and twenty-nine night shifts.

Moreover, the "Documentation Report" did not include the "Focus Rounding" for the staff members to record their hourly rounds during the night shifts for thirteen consecutives dates.

The resident's "Documentation Report" and the progress notes indicated that there was no documentation of the hourly rounding on the day and the night shift immediately prior one of the resident's falls.

The ADOC stated that staff members documented once a shift in the Point of Care (POC) under the task "Focus rounding" to confirm that their hourly round were performed. [211]

2. The resident's care plan dated on an identified date in 2022, indicated that the interventions were to verify the resident's continence needs before and after mealtimes and during the night.

The "Documentation Report" task within forty-four days and the resident's progress notes indicated that there was no documentation under the continence care for the following areas:

Bladder task:
- Two-day shifts,
- One evening shifts,
- Twenty-two the night shift.

Bowel task:
One day shift,
Two-night shifts,

Both "Bladder" and "Bowel" tasks:
One day shift,
Five evening shift, and
Five-night shifts.

The resident's "Documentation Report" and the progress notes indicated that there was no documentation for continence care for the previous night shift immediately prior one of the resident's falls.

The ADOC confirmed that the hourly rounding monitoring and the continence care were not documented as indicated in the resident's plan of care.

As the hourly rounding monitoring and the continence care for the identified above shifts were not documented, the risk was that the provision of care set out in the plan of care was not provided as specified in their plans for the resident.

Sources: A resident's health care records, and interview with the ADOC. [211]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident who exhibited altered skin integrity under an area of the resident's skin did not receive a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary:

The resident's progress notes indicated that a Registered Nursing Staff documented on an identified date, in the early morning that they observed the resident with an altered skin integrity area. During the late evening, another Registered Nursing Staff documented that the altered skin integrity was still present at the area of the skin and there was no complaint from the resident. Two days later during the evening, the resident received a skin assessment to the altered skin integrity area by another Registered Nursing Staff using their appropriate assessment instrument that was specifically designed for skin and wound assessment.

The Acting Director of Care (DOC) confirmed that the resident did not receive a skin assessment using their clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when the altered skin integrity was discovered. The assessment was done 2 days later.

As such, the resident did not receive a skin assessment related to the altered skin integrity of the skin area when it was discovered. The assessment was done 2 days later.

Sources: Resident's health care record and interviews with PSWs, Registered Nursing Staff and the DOC. [211]

WRITTEN NOTIFICATION: Accommodation Services: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

The licensee has failed to ensure as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, that the licensee shall ensure that procedures are developed and implemented for the cleaning and disinfection in accordance with evidence-based practice, if there are none, in accordance with prevailing practices related to contact surfaces.

Rational and Summary:

In accordance with O. Reg 246/22 s. 11. (1) (a) (b), the licensee is required to have in place a policy and procedure for the cleaning and disinfecting of high touch surfaces that is implemented in accordance with the Best Practice for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings #3rd edition, April 2018 and is complied with.

Specifically, the licensee did not comply with the two following documents:
-The Best Practice for Environmental Cleaning for Prevention and Control of Infections in All Health Care

Settings #3rd edition, April 2018.
- the Public Health Ontario as of July 16, 2021, titled "Coronavirus Disease 2019 (COVID-19), Key Elements of Environmental Cleaning in Healthcare Settings".

The Best Practice for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings #3rd edition, April 2018 indicated under section 3 "Cleaning Best Practices for Client/Patient/Resident Care Areas", subsection 3.2. "Frequency of Routine Cleaning" of paragraph 3.2.1 "High-and low-touch surface" that specified that cleaning and disinfection should be performed at least daily and more frequently if the risk of environmental contamination is higher.

The Public Health Ontario as of July 16, 2021, titled "Coronavirus Disease 2019 (COVID-19), Key Elements of Environmental Cleaning in Healthcare Settings" indicated that to clean and disinfect high touch or frequently touched surfaces at least once per day and more frequently in outbreak areas. Examples of these surfaces include doorknobs, call bells, bedrails, light switches, toilet handles, handrails, and keypads.

The Supervisor of Services and Environment stated that frequently touched contact surfaces, as well as the resident's bathrooms and floor are cleaned and disinfected at least once per day, and in outbreak areas more than once a day, seven days a week. However, the bedrails, call bells, light switches, doorknobs and other surfaces in residents' bedroom that are frequently touched contact surfaces are not cleaned and disinfected on Saturday and Sunday when the areas are not in outbreak.

As such, there was a potential risk for residents' health and safety when the home did not clean and disinfect the frequently touched contact surfaces in residents' rooms during the weekend as indicated above.

Sources: The licensee « Infection control routine practices Policy, the Best Practice for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings #3rd edition, April 2018, the Public Health Ontario as of July 16, 2021, titled "Coronavirus Disease 2019 (COVID-19), Key Elements of Environmental Cleaning in Healthcare Settings" and interview with the IPAC Lead and the Supervisor of Services and Environment. [211]