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

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Original Public Report

Report Issue Date: April 12, 2023	
Inspection Number: 2023-1508-0004	
Inspection Type: Complaint	
Licensee: Bruyère Continuing Care Inc.	
Long Term Care Home and City: Residence Saint-Louis, Ottawa	
Lead Inspector Joelle Taillefer (211)	**Inspector Digital Signature** Joelle Taillefer Digitally signed by Joelle Taillefer Date: 2023.04.14 15:09:06 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 23, 24, 27, 28, 2023, and March 2, 2023.

The following intake(s) were inspected:
Intake: #00011523 - related to continence care, falls prevention and management and resident care and support services.

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

Continence Care
Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)

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
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(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.

Rational and Summary:

1.On a date in 2022, a resident's health care records indicated that the resident presented with two health symptoms. Later during the day, the progress notes indicated that the resident's urine had a change of color and to repeat and take a urine specimen.

Five days later, the resident's health care records notes indicated that the attending physician ordered two identified tests.

Inspector #211 reviewed the resident's health care records within 6 days, and there was no documentation indicating that a staff member attempted to collect a urine sample during that time. Furthermore, there was no documentation that the physician was notified that the urine sample could not be collected by the laboratory for several days.

A Registered Nursing Staff stated that the resident's health condition change was communicated to the nurse of the subsequent shift and that the attending physician needed to be contacted related to the resident's health condition.

Another Registered Nursing Staff stated that the urine culture could not be collected in time for the laboratory staff to collect the urine sample on Friday at the end of the day. The laboratory staff were not returning until Monday.

2.A resident's most current care plan indicated to maintain adequate nutrition requirements estimating at a specific kilocalorie (kcal) daily and at a specific milliliter (ml) of fluids daily.

The Registered Dietitian (RD) stated that the average of resident's food intake consumption was below the requirement (50%) within 24 days on an identified month in 2022. The RD stated that the resident needed a minimum of 80% of fluids intake every day (daily). However, 38% of the time, the resident was under hydrated. The RD stated that the nursing staff on the unit should have reported to the RD when there was a decreased in the resident's quantity of food and fluid intake.

As such, the resident was placed at risk when the staff and others involved in the different aspects of the resident's care did not collaborate with each other in their assessment, development, and implementation of the resident's plan of care when the resident's health condition changed and when the resident's food and fluid intake decreased on an identified month in 2022.

Sources: Resident's health care records and interviews with the Registered Dietician and several Registered Nursing Staffs. [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 (10) (b)

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.

Rationale and Summary:

On an identified date in 2022, a resident's health care records indicated that the resident presented with two health issues. A medication was administered. The resident was tested, and the test result was negative. The resident was placed on isolation. On that day, the resident symptoms were monitored and noted to be fluctuating based on medication administered. Later during the day, the progress notes indicated that the resident's urine had a change in color. An identified condition in resident's urine was present after being tested via a test strip. The progress notes indicated to collect a urine specimen.

Two days later, the progress notes indicated that there was an identified condition in resident's urine. The isolation precaution was discontinued.

Five days later, the progress notes indicated that a procedure to collect urine was ineffective. Eleven minutes later, the attending physician notes indicated that the resident had two identified health conditions the previous week. There was no further health condition present, and one symptom appeared to be resolved. Furthermore, the attending physician notes indicated that an identified urine

test was taken but that no urine culture and sensitivity (C&S) test was done. The physician ordered a urine culture and other tests. The resident was sent to the hospital after a staff member observed a change in the resident's health condition.

Five days later, the resident's health care record indicated that the resident was admitted to the hospital with multiple health conditions.

A Registered Nursing Staff stated that the on-call physician was informed about the resident's health condition on a date in 2022, during the end of their shift. The on-call physician then requested to inform the attending physician about the resident's health condition. This information was communicated to the nurse of the subsequent shift that the attending physician needed to be informed of the resident's health condition. Additionally, the nurse was to read the report of the previous shift before starting their work.

The ADOC stated as the resident's specific health condition was within the normal range from the identified date in 2022, the resident's condition status did not need to be communicated to the physician until the physician was present in the home.

As such, a resident was placed at risk when the resident's health condition changed on an identified date in 2022, and the resident was not reassessed nor was the plan of care reviewed and revised until 5 days later.

Sources: Resident's health care records and interviews with the Vice President, Attending Physician, the Nurse Practitioner, ADOC, and several Registered Nursing Staffs. [211]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee shall ensure that any actions taken with respect to a resident under a program involving the provision of the care set out in the plan of care and the resident's responses to interventions related to hourly rounding, bladder and bowel and nutrition and fluid intake are documented.

Rationale and Summary:

A) A Resident's most current care plan in 2022, indicated to offer assistance for toileting during the

hourly rounding and proposing going into the bathroom after meals.

1.The "Documentation Report" tasks, indicated that there was no documentation related to the hourly rounding under "Focus Rounding" tasks for the following shifts for a month in 2022:
· 4 day and evening shifts because there was a "X" present for those two shifts, which prevented the staff members to record their interventions,
· One day shift,
· Eleven evening shifts,
· Five identified dates during the day and evening shifts.
Moreover, the "Documentation Report" did not include the "Focus Rounding" for the staff members to record their hourly rounds for twenty-three-night shifts.

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.

2.The "Documentation Report" task and the resident's progress notes indicated that there was no documentation under the continence care in an identified month within 24 days in 2022 as followed:
-Bladder task for ten evening shifts,
-Bowel task for one night shift, and
-For both "bladder" and "bowel" for the following shifts:
· Seven-night shifts,
· One day shift, and
· One evening shift.

B) The resident's most current care plan in 2022, indicated to maintain adequate nutrition requirements estimating at an identified amount in kilocalorie (kcal), at a certain amount per gram (g) of protein and an identified amount per milliliter (ml) fluids daily.

Review of the resident's "Documentation Report" and the progress notes during a month within 24 days in 2022 indicated that there was no documentation related to food and fluid intakes:
1. Under snacks:
· 2 shifts at 1030 hours-fluid intake,
· 2 shifts at 1430 hours, and
· 2 shifts at 1900 hours,
2. Under Meal Consumption:
· One date for breakfast and lunch, and
· One date for dinner.

The ADOC confirmed that the hourly rounding, continence cares and snacks and meals for the above shifts were not documented as indicated in the resident's plan of care.

As the hourly rounding, continence cares and the snacks and meals for the identified above shifts were not documented, the risk was that any actions taken related to the provision of care set out in the plan of care under a program were not provided as specified in their plans for the resident.

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