Ontario

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

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

Ottawa District
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Original Public Report

Report Issue Date: August 16, 2023	
Inspection Number: 2023-1508-0005	
Inspection Type: Complaint Critical Incident System	
Licensee: Bruyère Continuing Care Inc.	
Long Term Care Home and City: Residence Saint-Louis, Ottawa	
Lead Inspector Lisa Kluke (000725)	**Inspector Digital Signature**
Additional Inspector(s) Linda Harkins (126)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31, 2023 and August 1, 2, 3, 8, 9, 10, 2023.

The following intake(s) were inspected:

• Intakes: #00022069, CI#3013-000012-23, Intake: #00083910, CI#3013-000015-23 related to resident to resident abuse.
• Intake: #00022147 -Complaint related to alleged staff to resident abuse and care and services.
• Intake: #00092129 -Complaint related to concerns regarding care and services.
• Intake: #00092854 -Complaint related to concerns regarding resident care and services.
• Intake: #00093209, CI#3013-000030-23 - related to falls. The following intakes were completed: Intake #00020140, CI#3013-0000008-23 and Intake #00088464, CI#3013-0000024-23 also related to falls.

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

Resident Care and Support Services
Food, Nutrition and Hydration

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 239 (1) (e)

The licensee has failed to keep a transfer list consisting of the names of the residents of the home who are requesting a transfer from semi-private accommodation in the home to private accommodation in the home.

Rationale and Summary:

A resident was on the transfer list with no documentation related to the type of accommodation.

The transfer list was updated on a specified date indicating the request for a transfer to private accommodation.

Sources: Record review and interviews. [126]
Date Remedy Implemented: August 8, 2023.

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 responsive behaviours care needs changed and impacted the resident's personal care needs.

Rationale and Summary:
The resident's current plan of care indicated the following:
-related to dressing, bathing which included nail care and grooming indicated the resident resisted care which was last revised on a specified date three years ago.
-related to continence care that the resident is toileted before meals and at bedtime and to wear liner during the night which was last revised on a specified date two years ago.
-involve Behaviour Supports Ontario (BSO) as required for responsive behaviour needs which was last revised seven months ago.

A specified PSW and RPN reported this resident's cognitive impairment had deteriorated recently with increased resistance with their personal care needs. The resident refused current interventions attempted by nursing staff posing increased risk for falls and infection. This PSW and RPN indicated this resident was not involved with their BSO team.

As such, this resident's plan of care was not reviewed and revised when their care needs deteriorated related to resisting personal care, which negatively affected their personal care needs posing risk for falls and infection.

Sources: Resident observations, record review of resident health records, interviews with several nursing staff and the Acting DOC. [000725]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that when a specified Registered Nurse (RN) who had reasonable grounds to suspect that an alleged staff to resident abuse had occurred, immediately reported the

suspicion and the information to the Director.

Rationale and Summary:

On a specified date, a resident's family informed certain Personal Support Workers, RPN and an RN of an incident of alleged staff to resident abuse.

During this inspection, a specified Director Of Care (DOC) indicated that this RN was required to inform the Director immediately regarding this allegation of staff to resident abuse.

Record review of the specified critical incident report indicated this incident was reported by this DOC the day following the incident being reported to this RN.

As such, this RN failed to immediately notify the Director of an allegation of staff to resident that may place residents at potential risk of additional harm.

Sources: Critical incident report, record review and nursing staff and a specified DOC interviews.
[000725]

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

The licensee has failed to ensure that the doors leading to a specified stairway that preclude exit by a resident must be, kept closed and locked.

Rationale and Summary:

On a specified date during this inspection, Inspector #000725 observed the doors to the specified stairwell on a resident care unit that were not locked.

A specified Director of Care (DOC) reported to Inspector #000725 that these doors are always locked to prevent resident access.

A specified maintenance staff reported the keypad to these doors were disengaged for unknown reason thus leaving the doors unlocked.

As such, not having these doors leading to stairway locked posed a high risk to residents on this unit jeopardizing their safety for falls and injury.

Sources: Observations and interviews with specified DOC and maintenance staff. [000725]

WRITTEN NOTIFICATION: Menu planning

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (7)

The licensee has failed to ensure that meals and snacks are served at times agreed upon by the Residents' Council and the Administrator or the Administrator designate.

Rationale and Summary:

On a specified date, Inspector #126 observed five residents being fed breakfast at one hour and fifty minutes after the usual start time for their breakfast meal hour.

Resident's Council(RC) minutes for the past 12 months were reviewed and it was noted that there was no documentation of a discussion held about the meal and snacks times.

As such, the licensee failed to ensure that meals and snacks are served at times agreed upon by the RC for residents to have acceptable time frame in between meals.

Sources: Observations and record review [126]

WRITTEN NOTIFICATION: Police notification

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee has failed to ensure that the appropriate police service is immediately notified of an alleged incident of staff to resident abuse of a specified resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary:

On a specified date, the licensee reported a critical incident report to the Director regarding an alleged staff to resident abuse.

On this inspection, a specified DOC indicated that no police force were notified regarding this incident.

As such, failure in notifying the appropriate police service immediately of this alleged incident of staff to resident may place residents at potential risk for additional harm.

Sources: Critical incident report, investigation package review, resident record review and interviews with Administrator and a Director of care. [000725]