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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: January 12, 2024

Inspection Number: 2023-1508-0007

Inspection Type:
Complaint
Critical Incident

Licensee: Bruyère Continuing Care Inc.

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

Lead Inspector	**Inspector Digital Signature**
Megan MacPhail (551)	Megan K MacPhail Digitally signed by Megan K MacPhail Date: 2024.01.25 11:33:55 -05'00'

Additional Inspector(s)
Maryse Lapensee (000727)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 12, 13, 15, 18, 19, 20, 21, 22, 2023.
The inspection occurred offsite on the following date(s): December 28, 2023.

The following intakes were inspected:

These intakes were Critical Incident System (CIS) reports related to incidents that caused injuries to residents for which the residents were taken to a hospital and that resulted in significant changes in the residents' health conditions:

- #00099309 / CIS report 3013-000041-23
- #00100823 / CIS report 3013-000046-23
- #00102560 / CIS report 3013-000050-23

These intakes were complaints related to concerns about the care of residents:
- #00099781
- #00102243

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

Resident Care and Support Services
Infection Prevention and Control
Pain Management
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 (2)
Plan of care
Based on assessment of resident
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care was based on the needs of a resident.

Rationale and Summary

A resident was ordered a test, and the result indicated the presence of an infection.

A Registered Nurse (RN) notified the physician of the test result over one week later. A treatment was prescribed for the resident to meet their care needs.

The resident was at risk of complications when there was a delay in notifying the physician of the test result, indicating the presence of an infection, which delayed the initiation of a treatment.

Sources: A resident's health care record and interview with an RN.

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WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
Involvement of resident, etc.
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

The physician was to review the resident's medication regime with their SDM. This included any medications that were to be discontinued, changed to liquid format or to be crushed.

Medication changes occurred, and there was a note written to inform the resident's SDM of the changes.

An RN notified the resident's SDM after the changes were ordered.

By not involving the resident's SDM, they were not able to participate fully in the development and implementation of the resident's plan of care related to medication.

Sources: A resident's health care record and interview with an RN.

[000727]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A resident was assessed by a geriatric psychiatry team. It was recommended that the resident's mood and behaviours were documented on every shift, and this was added to the resident's plan of care.

The Administrator stated that on every shift, the Personal Support Workers (PSWs) were to document in Point of Care (POC), and the registered nursing staff were to document in the progress notes.

POC documentation was reviewed, and there were many day and evening shifts where documentation was not completed by the PSWs.

Registered nursing staff documentation was reviewed, and the resident's mood and behaviours were not documented on every shift daily. A Registered Practical Nurse (RPN) stated that if the resident did not exhibit any behaviours, they did not write a progress note.

By not documenting the resident's mood and behaviours, the information could not be fully analyzed in order to support the resident as required.

Sources: A resident's health care record and interviews with the Administrator and an RPN.

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WRITTEN NOTIFICATION: Required Programs: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the Post-Fall Management procedure.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

Specifically, staff did not comply with the policy "Falls Prevention, Long-Term Care" which was included in the licensee's falls prevention and management program.

Rationale and Summary

The Falls Prevention policy directed that:
Following an unwitnessed fall, the registered nursing staff were to immediately complete and document a clinical assessment of the resident, including a Neurological Assessment. The Neurological Assessment was to be completed with the post-fall assessment, within one hour of the initial assessment and every shift for 48 hours or as per physician recommendation;
For falls without serious injury, between specific hours, the registered staff notified

the attending physician or replacement;
If the resident experiences or has any of the following, the RN notifies the physician immediately: b) sustained a serious injury, c) requires transfer for further intervention and appropriate level of care.

A resident had an unwitnessed fall.

They were assessed by an RN who completed a Neurological Assessment with the post-fall assessment. A repeat Neurological Assessment was not completed within one hour of the initial assessment.

The physician was not contacted. The RN stated that they wrote a note in the communication book requesting that the resident be sent to hospital the following day for an x-ray to rule out a fracture.

The Director of Care (DOC) stated that a Neurological Assessment was not completed within an hour after the initial assessment, and that the physician was not contacted after the resident fell.

The resident was sent to hospital the following day, and they were diagnosed with an injury that was sustained as a result of the fall.

By not repeating the Neurological Assessment, any change that may have suggested a head injury was missed. By not contacting the physician, any possible orders or instructions were missed.

Sources: A resident's health care record, the Pain Management, Long-Term Care policy and interviews with an RN and the DOC.

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COMPLIANCE ORDER CO #001 Required Programs: Pain Management

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Educate all registered nursing staff on the home's Pain Management policy.
2) Select five residents who experienced a significant change in their pain status. Complete a weekly audit on each of the five residents, starting with the significant change in pain status, for four consecutive weeks, to determine if the home's pain management policy was complied with.
3) Take corrective actions if the audits determine non-adherence with the pain management policy.
4) Keep a written record of 1-3.

Grounds
The licensee has failed to comply with the pain assessment and management procedure.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a pain management program to identify pain in residents and manage pain, and it must be complied with.

Specifically, staff did not comply with the policy "Pain Management, Long-Term Care" which was included in the licensee's pain management program.

Rationale and Summary

The Pain Management, Long-Term Care policy stated that:
All residents were to be assessed for pain when they exhibited a significant change in pain status and when pain was not consistently relieved by pharmaceutical and non-pharmaceutical interventions.
The RN and RPN were to collaborate with the interdisciplinary team to ensure that residents with suspected pain or discomfort were appropriately assessed, and if present, pain was managed.
RN and RPN documentation was to be completed as a specific Pain Assessment, in the Vital Signs tab or as a Pain Progress Note, as appropriate.

A resident's pain scale was recorded as zero, twice on the same day, before they had an unwitnessed fall.

In the post-fall assessment, it was documented that the resident reported pain to a specific body part. A pain scale was not recorded.

While sitting in their wheelchair, after the fall, the resident was not acting as per their norm, and they were in too much pain to go to the dining room to eat their meal.

The RPN reported the resident's pain to the RN, and the RPN administered the resident's regularly scheduled dose of pain medications. The pain scale with the administration of the medications was recorded as "NA".

The resident's pain scale was recorded once during the shift in which the fall occurred. Three hours after the administration of their regularly scheduled pain medications, the resident's pain scale was high, and they received one dose of a pro re neta (prn) medication. Several hours later, the medication was documented as being effective. The effectiveness of the medication was based on an observation of the resident from the doorway of their room.

The resident expressed being in pain, including severe pain, with any movement of a body part, including when they were transferred from their wheelchair to bed. At bedtime, care could not be completed as per the resident's normal routine due to pain.

When the RN completed an assessment of the resident, they documented that the resident reported pain to a specific body part, had pain with movement and that the day RN would follow-up with the physician. A note was written in the communication book to have the physician send the resident to hospital the following day for an x-ray to rule out a fracture.

Near the end of their shift, the RPN documented that the resident reported having too much pain in a specific body part to allow for an assessment, as ordered by the physician, of the opposite limb. The RPN did not physically assess the part of the resident's body that they reported was painful.

When the resident received their last regularly scheduled dose of a pain medication for the day, the pain scale level was coded as "NA".

A PSW stated that the resident was showing pain on their face and saying that a specific body part hurt, and that the pain seemed to worsen over time.

A PSW reported to the RPN that the resident was in a lot of pain at least twice during their shift. The RPN reported the resident's pain to the RN several times and indicated that the pain was serious and questioned if the physician should be called or the resident sent to hospital.

The following day, a PSW reported the resident's condition to the RN, and the physician was contacted. Tthe resident was sent to hospital where they were diagnosed with an injury.

The resident's pain was not assessed, using the Pain Assessment, Vital Sign tab or Pain progress note, when they repeatedly expressed pain after their fall, as their pain was not managed for prolonged periods of time between their fall and transfer to hospital.

The resident's quality of life was compromised after their fall and onset of pain which was not assessed and managed as per policy.

Sources: A resident's health care record, the Pain Management, Long-Term Care policy, and interviews with staff.

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This order must be complied with by February 23, 2024

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;
(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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.