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: March 20, 2024

Inspection Number: 2024-1508-0001

Inspection Type:
Critical Incident
Follow up

Licensee: Bruyère Continuing Care Inc.

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

Lead Inspector	**Inspector Digital Signature**
Kelly Boisclair-Buffam (000724)	Kelly Boisclair-Buffam Digitally signed by Kelly Boisclair-Buffam Date: 2024.04.03 14:38:04 -04'00'

Additional Inspector(s)
N/A

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 27, 28, 29, 2024 and March 1, 2024.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00019100/CI# 3013-000006-23 related to alleged staff to resident physical / emotional abuse.
- Intake: #00097614/CI# 3013-000036-23 related to Rhinovirus Outbreak.
- Intake: #00103874/CI# 3013-000052-23 related to alleged resident to resident unlawful conduct.
- Intake: #00104011/ CI# 3013-000053-23 related to alleged resident to resident physical abuse.

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The following follow up intake(s) were inspected:

- ·Intake: #00106438 - 1st Follow-up CO#001 O. Reg. 246/22 , s. 53 (1) 4 related to pain management - compliance due date February 23, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1508-0007 related to O. Reg. 246/22, s. 53 (1) 4. inspected by Kelly Boisclair-Buffam (000724)

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when multiple residents demonstrated responsive behaviours, that actions were taken to respond to the resident's needs, including assessment, reassessments, interventions, and that the resident's responses to interventions are documented.

Rationale and Summary
#1
A review of a resident's plan of care, identified that the resident had a history of physical behaviors. The resident had been followed by an outside specialized health care team and had been placed on a monitoring tool prior to this recent incident. Since the residents' admission to the home, they also had in place, a 1:1 surveillance during specific hours.
On a specific day, an incident of alleged physical abuse occurred from the resident towards a co-resident. The first resident had then been placed on a 24/7, 1:1 surveillance and the homes' Behavioral Support Ontario (BSO) team instructed the staff to complete the monitoring tool every day and every shift with no end date. Upon review of this resident's monitoring documentation post incident, there were multiple missed date and time entries.

The Registered Practical Nurse (RPN), BSO Lead and the Director of Care (DOC) confirmed that the monitoring tool is to be completed every day and every shift. The DOC and the BSO Lead both acknowledged the missing entries and stated that the

expectation is to complete the tool as directed.

As such, failing to complete the documentation of the monitoring tool for this resident, potentially increased the risk of their physical responsive behaviours not being fully analyzed and evaluated, placing other residents at risk for physical aggression.

Sources: Resident progress notes, care plan, and the monitoring tool for identified dates , interviews with RPN, BSO Lead and DOC.[000724]

Rationale and Summary
#2
A review of an other residents' plan of care indicated a history of physical behaviors. The resident had been on a monitoring tool and for specific hours, a 1:1 surveillance. On an identified day, an incident of alleged physical abuse occurred by this resident towards a co-resident. The first resident was to remain on their 1:1 surveillance and the homes' Behavioral Support Ontario team instructed the staff to complete the monitoring tool post recent incident every day and every shift with no end date.

Upon review of the tool leading up to and following the specific incident, there were multiple missed date and time entries.
The Registered Practical Nurse (RPN), BSO Lead, a Personal Support Worker (PSW) and the Director of Care all confirmed that the tool was to be completed every day and every shift. The DOC, BSO Lead and the PSW all acknowledged the missed entries and stated that the expectation was to fully completed the monitoring tool as directed.

As such, failing to complete the documentation of the tool for the identified resident, potentially increased the risk of their physical responsive behaviours not being fully

analyzed and evaluated, placing other residents at risk for physical aggression.

Sources: Resident's progress notes, care plan and their monitoring documentation for a specific time period, interviews with RPN, BSO Lead, PSW and DOC #1113 .[000724]