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: June 4, 2024	
Inspection Number: 2024-1508-0002	
Inspection Type: Critical Incident	
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)	

INSPECTION SUMMARY

The inspection occurred onsite from May 2-3, 7-10, 2024.
The following intakes were inspected:

- Intakes: #00110319, #00111506 related to significant change in condition after falls and,
- Intakes: #00111676 and #00112801 related to falls prevention.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstance of an unexpected death of a resident in the home.

Rationale and Summary:
The Clinical Manager indicated during an interview that they were made aware of the unexpected death of a resident on a specified date, while reviewing morning unit reports. This resident died after this incident. The Clinical Manager submitted a Critical Incident System (CIS) report to the Director as it was not completed the day of the incident.

The Administrator indicated during an interview that the Registered Nurse (RN) that was in charge at the time of this incident, did not call the after-hours emergency contact to report this unexpected death to the Director.

As such, the licensee did not immediately inform the Director of a resident's unexpected, sudden death, post fall.

Sources: A resident's health care records, interviews with Clinical Manager and the Administrator. [000725]