Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 11, 2014	2014_225126_0031	O-001257-14	Complaint

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET, OTTAWA, ON, K1N-5C8

Long-Term Care Home/Foyer de soins de longue durée

ÉLISABETH-BRUYÈRE RESIDENCE
75 BRUYERE STREET, OTTAWA, ON, K1N-5C8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 27, 28, 2014

During the course of the inspection, the inspector(s) spoke with the Advanced Practice Nurse for Long Term Care & Clinical Manager, the Manager in the Workplace, one Registered Nursing Staff, several Registered Practical Nurses, several Personal Support Workers, one Physiotherapist Assistant and the Unit Clerk.

During the course of the inspection, the inspector(s) reviewed one resident health care record and observed care and services provided to the resident.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Minimizing of Restraining
Pain
Personal Support Services
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, 2007, S. O. 2007, c.8, s. 31. (2)4 in that Resident #001's plan of care did not include an order by the physician or the registered nurse in the extended class.

On November 27 and 28, 2014, resident # 001 was observed to be sitting in a wheel chair(w/c) with a front closure lap belt. Resident # 001 was unable to undo the belt.

S# 101, 103 and 106 indicated to Inspector # 126 that the belt was applied to prevent the Resident from falling out of the w/c , that the Resident was sliding down the w/c on occasions and that the Resident was not able to undo the front closure lap belt.

Resident #001's health care record was reviewed and it was noted that there was no physician order for the front closure lap belt since the Resident returned from the Hospital on a specific date in November 2014.

S# 101 called the Physician on November 28, 2014 to obtain an order for a front closure lap belt restraint. The monitoring tool was implemented and staff were informed. The Clinical Manager was informed by S# 101 and by Inspector # 126, that Resident # 001 now had an order for the front closure seat belt and the restraint requirements were implemented. [s. 31. (2) 4.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 130.1 in that the licensee did not ensure that all areas where drugs are stored shall be kept locked at all times, when not in use.

On November 28, 2014 around 08:35 am, Inspector # 126 observed the medication cart to be left unlocked and unattended in the hallway in front of the dining room on the dementia unit. Two pills, an orange and a white pill were left on top of the medication cart and the cart was unlocked leaving all medications in unlock drawers. Inspector # 126 looked around to see if any Registered Nursing Staff was within site and no one was found.

Registered Nurse S# 101 came out of the nursing/report office and came down the hallway. S #101 was informed that the medication cart was left unlocked and that 2 pills were left on top of the medication cart. Both medications were given to S #101. The medication cart was locked at that time by S #101. S #101 indicated that Registered Practical Nurse S #102 was in the nursing/report office.

. [s. 130. 1.]

Issued on this 11th day of December, 2014

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs