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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 13, 2017 | 2016_219211_0026 | 026983-16 | 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

JOELLE TAILLEFER (211)

### 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 15, 16, 17, and 18, 2016.**

**The concurrent complaint inspection Log #026983-16 was related to residents #001's Responsive Behaviours, and resident #002's Nursing and Personal Support Services, and Continence Care and Bowel Management .**

**During the course of the inspection, the inspector(s) spoke with the Executive Director Long-Term Care, Director of Care (DOC), Physician, Administrative Assistant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Attendants (PCA), Personal Care Attendants and Behavioural Support of Ontario (PCA/BSO), Director of Mission, Ethics, Compliance and Client Relations, and the family members.**

**During the course of inspection, the inspector observed delivery of care, reviewed Resident Health Care records and the staffing schedules.**

**The following Inspection Protocols were used during this inspection:**
**Personal Support Services**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

Resident #002 was admitted on an identified date, diagnosed with cognitive impairment and other medical heath issues. The health care records indicated that the resident had responsive behaviours and required two staff assistance for activity of daily living (ADL) such as dressing, bathing and hygiene care. Resident #002 was discharged from the home four months later.

Resident #002's plan of care on an identified date, indicated that the resident required two staff assistance during bathing due to unpredictable behaviours. The resident's bath schedule was entered in the written plan of care on an identified date, to bath the resident on two identified days during the week.

Review of the resident's health care records was conducted by the inspector. It was noted that there were no documentation relating to the resident's bath for an identified month. The resident's progress notes for an identified date, indicated that the resident received a bath with the assistance of a Behavioural Support Ontario Staff (BSO) and a personal support worker (PSW). The resident's progress notes on an identified date, indicated that the resident received a specified type of bath with the assistance of both a

family and a staff member.

The resident care unit bathing schedule indicated that the resident was to have baths on identified days. However, no documentation was found relating to this provision or any bath refusal by the resident.

On a specified date, a family member reported that the resident was scheduled to receive a bath on two specified days during the week. The family also stated that:
• The staff had not given the resident's baths.
• The family members were not informed that the resident was refusing baths.
• They requested to have the resident's bathing given during an identified shift when the family is present, but the staff refused because the health care record did not indicate to give the resident's bath during that specified shift.

On an identified date, interview with the PSW/BSO #113 stated that she informed the family members shortly following the resident's admission, that the resident was refusing the identified baths. PSW/BSO #113 stated the staff was only able to give the resident's baths when an identified family member was present. The plan was to give the resident's bath only when family member was present with the assistance of a staff member when the resident was refusing to be washed.

On an identified date, interview with RPN #112 indicated that the resident was refusing to bathe with staff assistance. RPN #112 acknowledged that the resident was having the identified bath with the presence of a family member and the assistance of a staff member.

Interview with Programmer Analyst and the DOC who both acknowledged that the provision of the resident's bath should have been documented in the resident's health care record when the bath was given or when the bath was not given and the reason for not providing the bath.
The licensee has failed to document the provision, the outcomes and the effectiveness of the plan of care relating to the resident's bath on an identified days. [s. 6. (9)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

Resident #002 was admitted on an identified date, diagnosed with cognitive impairment

among other medical health issues. The health care record indicated that the resident had responsive behaviours toward staff during provisions of care.

Review of resident #002’s Medication Administration Record (MAR) for a period of approximately six weeks, indicated to administer ten identified regular scheduled medications.

Resident #002’s MAR revealed that the resident refused his/her medication for 16 days at 0900 hours, and an identified date at 2000 and 2100 hours, within the six weeks following admission. The resident's progress notes within these six weeks indicated that the resident refused his/her medications on six identified dates following several attempts.

Review of the resident’s progress notes on an identified date, indicated that an identified family member was informed that the resident had responsive behaviours and was refusing his/her medications. A family conference meeting was scheduled with the identified family member approximately six weeks following the resident's admission to review the plan of care and the medications administration. The progress notes indicated that the family conference meeting occurred five days prior to the scheduled date.

The resident’s Physician’s Digiorder prescribed on the day of the family conference meeting indicated to change seven identified morning medications to 1700 hours and the resident was noted to accept his/her medications.

Interview with RPN #107 on an identified date, stated that she notified the physician that the resident was refusing his/her medications during the first month following admission. However, she forgot to document this information.

Interview with RPN #108 on an identified date, indicated that the family was notified during the first month following admission that the resident was refusing his/her medications. RPN #108 indicated that the family suggested that the staff should try different approaches to administer the medications.

Interview with RN #105 on an identified date, stated that she left a message in the DOC’s voicemail fourteen days following the resident's admission that a specified family member wanted to discuss the resident's behaviours with the team prior to the six weeks family conference.

Interview with the DOC on an identified date, stated that it is the responsibility of the registered staff (RN and RPN) to inform the DOC and the physician when a resident is refusing his/her medications. The DOC stated she was not informed that resident #002 was refusing his/her medication. The DOC stated " If a resident with cognitive impairment refused to take his/her medication, the staff should try other alternatives to administer the medications such as returning later during the day to offer the resident's medications, or put the medications in the food and that these interventions should be added to the resident's plan of care. The effectiveness of the interventions should be evaluated and reassessed."

Interview with the Physician on an identified date, stated that her notes indicated that she was informed by the staff on an identified date (approximately four weeks following the resident's admission) that the resident was refusing his/her medications and that a family conference meeting was booked for the following week. The physician stated that she indicated in the resident's progress notes on the day of the family conference meeting, that since the resident was frequently refusing his/her 09:00 hours medications, it would be preferable to move the majority of his/her medications during supper time because the family was usually present at that time.

The licensee has failed to ensure that the resident was reassessed when the resident's care set out in the plan was not effective relating to his/her refusal to accept medications for several days that started on the fifth day following admission until the resident plan of care was reviewed and revised during the family conference meeting approximately five weeks later. [s. 6. (10) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at any other time when the care set out in the plan has not been effective when a resident is refusing his/her medication and to ensure that the following are documented related to bathing:***
***1. The provision of the care set out in the plan of care.***
***2. The outcomes of the care set out in the plan of care.***
***3. The effectiveness of the plan of care, to be implemented voluntarily.***

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**Issued on this 14th day of February, 2017**

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

**Original report signed by the inspector.**