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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 12, 2018	2018_619550_0006	004362-18, 004363-18	Follow up

Licensee/Titulaire de permis

Bruyère Continuing Care Inc.
43 Bruyère Street OTTAWA ON K1N 5C8

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

Élisabeth-Bruyère Residence
75 Bruyère Street OTTAWA ON K1N 5C8

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

JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 1, 2, 5, 6, 7, 8, 9 and 10, 2018.

This inspection is a follow-up inspection for CO #001 and CO #002.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of care (DOC), registered nurses (RN), a registered practical nurse (RPN), personal support workers (PSW), the Behaviour Support Ontario champion (BSO) and a resident.

The inspector also reviewed resident's health care records, observed care provided to residents and reviewed education provided to staff including attendance to this education.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (4)	CO #002	2018_548592_0002	550
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_548592_0002	550

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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes:
• any mood and behaviour patterns, including wandering
• any identified responsive behaviours
• any potential behavioural triggers and variations in resident functioning at different times of the day.

During a review of resident #001's health care records, inspector #550 noted documented that this resident had specific responsive behaviours. It was documented in the progress notes and POC (Point of Care) that the resident exhibited a specific responsive behaviour fifteen times and exhibited another specified responsive behaviour six times in a specified three month period.

During interviews, BSO staff #102, PSW #103 and RPN #100 indicated to the inspector that when the resident is exhibiting a specified responsive behaviour, it is sometimes due to a specific medical condition caused by the resident not being compliant to a specific treatment or staff are not taking the necessary steps to ensure that the equipment required for the treatment is functional. Staff now make sure the resident is compliant to the treatment by ensuring the resident is using the specified equipment and will verify the piece of equipment twice per shift and take the necessary steps to ensure it is functional. When the resident is exhibiting another specific responsive behaviour, it is because of a specified trigger and a device is used to assist staffs in managing this behaviour.

The resident's actual plan of care was reviewed by the inspector. The plan of care did not include these two specific responsive behaviours with the identified triggers.

The DOC indicated to the inspector that resident #001's two specified responsive behaviours and the identified triggers were not included in the plan of care.

As evidenced, two specified responsive behaviours and the behavioural triggers were not included in resident #001's plan of care. [s. 26. (3) 5.]

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 responsive behaviour plan of care for resident #001 is based on an interdisciplinary assessment of the resident that includes:
• any mood and behaviour patterns, including wandering
• any identified responsive behaviours
• any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, ii. that is secure and locked.

On a specified date, inspector #550 observed RPN #100 leaving the medication cart unattended in the hallway on a specified unit. The medication cart had medication on top of it and the second drawer of the medication cart was left ajar. The RPN went to see a resident in a specified dining room which is in a location not visible from the medication cart's location. The inspector observed on top of the medication cart two bottles of two different medication labelled to specified residents. At the time of this observation, there were residents nearby. The inspector stayed at the medication cart until the RPN returned approximately four minutes later. The inspector asked RPN #100 if it was regular practice for them to leave the medication cart unlocked with medication on top while unattended. The RPN responded by asking the inspector if the inspector expected them to close the medication bottles and store them inside the medication cart each time they left the medication cart. The inspector referred the RPN to the home's policy.

Discussion with the Administrator/Clinical Manager and the DOC. They both indicated that it was not the first time RPN #100 was found to have left the medication cart unlocked and unattended and that they had previously been disciplined for this. They indicated that all medications are to be stored inside the medication cart and the medication cart is to be locked when it is left unattended.

As evidenced, the medications were not stored in an area or a medication cart that was secured and locked. [s. 129. (1) (a)]

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 drugs are stored in an area or a medication cart, that is secured and locked, to be implemented voluntarily.

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Issued on this 13th day of June, 2018

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

Original report signed by the inspector.