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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 17, 2019	2019_583117_0025	016021-18, 025883-18, 030182-18, 000461-19, 003802-19, 010690-19	Critical Incident System

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

LYNE DUCHESNE (117), LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 29, 30, 31, June 3, 4, and 5, 2019

The following critical incident inspections were conducted concurrently during this inspection:

- Log # 016021-18: related to critical incident CIR # 2759-000018-18 reporting the unexpected death of a resident

- Log # 025883-18: related to critical incident CIR # 2759-000026-18 reporting the unexpected death of a resident

- Log # 030182-18: related to critical incident CIR # 2759-000029-18 regarding an incident of alleged resident to resident physical abuse.

- Log # 000461-19: related to critical incident CIR #2759-000001-19 regarding a medication management systems incident.

- Log # 003802-19 related to critical incident CIR #2759-000003-19 regarding an alleged incident of resident to resident sexual abuse

- Log # 010690-19: related to critical incident CIR #2759-000008-19 regarding an alleged incident of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with with the home's Administrator, Director of Care (DOC), several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), the Registered Dietitian (RD), a Nutritional Manager, several Dietary Aides, housekeeping staff as well as to several residents.

During the course of the inspection, the inspector(s) reviewed several residents health care records, observed the provision of resident care and services, reviewed the licensee's policies CLIN CARE 33 LTC: Fall Prevention, Long-Term Care, effective 2015-12 and Medication 06-02 LTC: Medication Transcription, Order Verification, Receipt of Medications, Long-Term Care, effective 2018-01.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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	Légende 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately notified of an allegation of sexual abuse. (Log # 010690-19)

A Critical Incident Report CIR #(2759-000008-19) was submitted to the Director on a specified day in 2019, for an allegation of sexual abuse.
On a specified day in 2019, resident #001 touched resident #003 inappropriately. Resident #003 informed Physio Assistant Therapist (PTA#112) and Housekeeping staff #113 immediately after the incident occurred. Both staff did not report the incident immediately.

The Administrator became aware of the incident three (3) days later and submitted a CIR.

As such, the licensee did not notify the Director immediately on the specified day in 2019. [s. 24. (1)]

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 Director is immediately notified of an incident of alleged of abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies are implemented in accordance with evidence-based practices. (Log # 000461-19)

A Critical Incident Report CIR #2759-000001-19 was submitted to the Director on a specified day in 2019, regarding a medication management systems incident.

On a specified day in 2019, RN #106 wrote a telephone order for resident #004. The order, written during the attending physician's visit to the home, indicated the discontinuance of a specified medication, both regular and on an as needed basis. The order was not countersigned by the attending physician at the time of the attending physician's visit. The discontinuance of the medication orders were transcribed by RN #106 in the resident's medication administration record. The orders were not verified and transcribed by the receiving RN #121. Five (5) days later, the resident's attending physician re-prescribed the medication.

The home's Medication policy #06-02 LTC: Medication Transcription, Order Verification, Receipt of Medications identifies the following:

2.1.3.1 Telephone orders are acceptable, but must be countersigned by the attending or covering physician at their next visit. All telephone orders must be read back to the ordering physician.

2.1.3.2 Verbal orders (e.g., orders received through face-to-face interaction only, when the prescribing physician is present) are accepted only in exceptional situations, where the prescribing physician cannot document the orders, such as during a procedure. Verbal orders must be written in the resident's health record as soon as possible by the authorized professional who received the order, and the order must be countersigned by the attending or covering physician as soon as possible. These orders must be transcribed onto the electronic medication administration record (eMAR) by the receiving nurse.

The home's Administrator said that RN #106 did not follow the licensee's policy related to medication transcription and order verification. RN #106 should have written a verbal order, not a telephone order when the attending physician was at the long-term care home on the specified day in 2019. The order was not countersigned by the attending physician as soon as possible. The order was also processed by RN #106 and not by the receiving RN #121, who was working the next shift. As such, RN #106 did not followed the licensee's policy related to medication transcription and order verification on a specified day in 2019.

It is noted that a CO #002 O.Reg. 79/10, s. 114 (3) related to medication management systems was issued February 12, 2019, under inspection # 2018_621547_0036 with a compliance due date of April 30, 2019. The above reported incident occurred prior to the compliance due date and therefore is being issued as a written notification. It is noted that the CO #002 was found to be in compliance as per Inspection # 2019-583117-0024 which was conducted concurrently as this inspection. [s. 114. (3) (a)]

Issued on this 17th day of June, 2019

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

Original report signed by the inspector.