Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Dec 29, 2020	2020_683126_0024	003785-20, 017718-20, 021214-20	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

LINDA HARKINS (126)

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): November 20 (on site), 24, 25, 26, 27, 30 and December 1, 2020

Log #003785-20 Follow up related to plan of care
Log #017718-20, Critical Incident (CI) #27759-000012-20 and log #021214-20, CI #2759-000013-20 related to unexpected deaths

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director Of Care (DOC), several Registered Nurses(RNs), several Registered Practical Nurses(RPNs) and several Personal Support Workers (PSWs).

During the course of the inspection the Inspector reviewed the resident's health care records.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention
Nutrition and Hydration
Personal Support Services

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)**

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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2020_818502_0004	126

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff communicated accurate assessment of resident #002 in the shift report.

Resident #002 was admitted on a specific date in 2020, was communicative and was able to walk from the bed to the wheelchair with the walker. Few days later, the resident had an episode of sweating and was not responding to verbal stimuli. On a specific day, the resident was no longer able to walk with the walker and required two staff side by side to walk. The resident's condition deteriorated over a few days before passing.

In the interviews conducted with staff, it was reported that resident #002 vomited and was sweating and needed to be changed a second time during the shift. RN and RPN were only aware that resident had one episode of sweating not two episodes.

Also, on a specific shift, RN and RPN received report and were told that resident #002's condition was fine when in fact the resident had vomited the previous shift.

Furthermore, during the interviews, several registered nursing staff were not aware that resident #002 presented with symptoms and their condition had changed over those few days.

Sources: Resident #002 progress notes; and interviews with RN #107 and other staff. [s. 6. (4) (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 the licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

Issued on this 11th day of January, 2021

[redacted]

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

Original report signed by the inspector.