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
Nov 18, 2021	2021_683126_0016	006141-21, 006349-21	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

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): October 28, 29, November 1,2,4,5,8, 2021

The purpose of this inspection was to conduct a Critical Incidents inspection related to:
Log #0061141-21, Critical Incident(CI) #2759-000006-21, allegation of sexual abuse, resident to resident
Log # 006349-21, CI #2759-000021-21, allegation of physical abuse, resident to resident

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Assistant (PCAs) and residents.

The resident health care records were reviewed. Observations of care and services provided to residents was done. The Infection Control Observation checklist was conducted concurrently with this inspection and documented under inspection #2021_683126_0015.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
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 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004’s behavioural trigger was identified for the resident who demonstrated responsive behaviours by refusing to come out of the bathroom while sharing a room with a roommate.

On a day in 2021, resident #004 opened resident #003’s privacy curtain while looking for the bathroom. Resident #003 was upset with resident #004 and they both got into in a verbal altercation.

Eight days later, resident #004 followed resident #003 into the bathroom and resident #003 got upset. Both residents got into a physical altercation that resulted in an injury for resident #004. Resident #004 was relocated to another bedroom.

Two days after the last incident, resident #004 wandered in the prior bedroom and went to the bathroom. The resident refused to leave the bathroom. Resident #003 wanted to use the bathroom but resident #004 refused to come out. Both residents got into a verbal altercation.

Discussion with nursing staff who worked during those incidents indicated that in the evening and night shift, resident #004 had responsive behaviour by looking in the mirror, talking to themself and refusing to come out of the bathroom.

The plan of care did not identify that the mirror in the bathroom was a behavioural trigger and no intervention were in place to address this responsive behaviours.

Sources: Review Critical incident and Interviews with DOC #002 and other staff. [s. 53. (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, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 19th day of November, 2021

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

Original report signed by the inspector.