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
Nov 18, 2021	2021_683126_0015	006786-21	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): October 19, 20, 21, 22, 26, 27, 28, 29, November 9, 2021

The purpose of this inspection was to conduct a complaint inspection, Log # 006786-21 related to care and services such as continence care and bowel management, hydration and nutrition, pain, skin and wound, fall management and complaint and reporting.

In addition, the Inspector reviewed resident's health care records, the Short Term Symptom Management Orders, emails communications between the complainant and the Licensee and policy (RH.HR 9.16) COVID-19 Vaccination, revision date 2021-09-07.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurses (RNs), Registered Practical Nurses (RPNs), the Registered Dietitian (RD), Personal Care Assistants (PCAs), one housekeeping staff, residents and a family member.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 had a plan of care to promote and manage bowel continence.

Resident #001's Documentation Survey Reports (DSRs) were reviewed for a specific period in 2019 for bowel monitoring. On several occasions, it was documented that the resident did not have a bowel movements for three days periods and no interventions were implemented.

Discussion with the Director of Care(DOC) #002, who indicated that, they are notified by Point Click Care (PCC) that the resident did not have a bowel movement for a period of three days. Following that notification, the nurse would administer a suppository as per the "Short Term Symptom Management Orders" document. If the suppository is ineffective, the nurse would call the physician to obtain an order for medication to manage constipation.

Resident #001's Medication Administration Records (MARs) were reviewed and no suppository or other medication were administered to resident #001 when the resident was identified to not have had bowel movements for three days.

Resident #0001 plan of care did not promote and managed interventions for the resident's constipation.

Sources: DSR. MAR and interviews with DOC and RPNs [s. 51. (2) (b)]

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 shall ensure that every licensee of a long-term care home shall ensure that, (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 who had a change in 5 per cent of body weight was assessed using an interdisciplinary approach and action are taken.

Resident #001's monthly weights were reviewed, and it was noted that there was a change in 5 per cent body weight loss between a specific period in 2019. No interventions were documented related to the resident’s weight loss.

In 2019, it was documented in the progress note that the resident was not eating much and had difficulty swallowing. No interventions or referral to the RD were documented.

Discussion with PCA #109, who indicated that they can either document the resident's weight on a specific document or on PCC. They stated that the nurse would follow-up with the RD if there were any weight changes.

Discussion with the Registered Dietician (RD) #108, who indicated that they were not aware of resident #001's weight loss. The RD stated that they do not review monthly weights on a regular basis and rely on the nurses to notify them of any weight changes or high-risk residents. The RD indicated that when they receive a referral for assessment, it is usually done by phone or in person.

Discussion with Administrator #100 and DOC #101 who both indicated that referral to the RD was usually done by phone or in person and most of the time the referral is done by the nurse. The RD indicated that the nurses can implement some dietary interventions without completing a referral.

Sources: resident #001 health are records and interviews with the RD and other staff [s. 69.]

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 every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the six-week post admission care conference was held for resident #001.

Resident #001 was admitted in 2019 and three months post admission the care conference still had not been held.

Sources: Resident health care record and interview with the Administrator. [s. 27. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written complaint related to resident #001 was reported to the Director and the complaint was responded in writing to the complainant.

In 2020, the complainant sent an email to the Licensee expressing several concerns related to the care and services of resident #001. This complaint letter/email was never reported to the Director and the Licensee did not respond in writing to the complainant at that time.

Sources: reviewed of emails and interview with the Administrator [s. 103. (1)]

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.