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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Amended Public Report (A1)

Report Issue Date June 16, 2022
Inspection Number 2022_1250_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Bruyère Continuing Care Inc, Ottawa

Long-Term Care Home and City
Élisabeth-Bruyère Residence, Ottawa

Inspector who Amended
Joelle Philippon-Taillefer (211)

Inspector who Amended Digital Signature
Joelle Taillefer Digitally signed by Joelle Taillefer
Date: 2022.06.23 15:13:02 -04'00'

AMENDED INSPECTION REPORT SUMMARY

The public inspection report has been revised to reflect the correction in the wording "plan of care" and clarified the licensee and the Long-Term Care Home name. The complaint #007171-22 and the critical incident system #007036-22, inspection #2022_1250_0001 was completed on April 14, 26, 27, 28, 2022 and May 3, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 14, 26, 27, 28, 2022 and May 3, 2022 (Onsite).

The following intake(s) were inspected:
Intake # 007036-22 (CIS) and Intake # 007171-22 (complaint) related to Falls Prevention and Management and injury that caused a significant change in health status.

The following **Inspection Protocols** were used during this inspection:
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)

WRITTEN NOTIFICATION O.REG. 79/10 S. 15 (1) (A)

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

The licensee has failed to ensure that where bed rails are used, a resident was assessed, and the resident's bed system was evaluated in accordance with evidence-based practices and if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Rationale and Summary

A residents health care records indicated that the resident slid out of bed and sustained a fall. The resident was assessed and noted to have sustained an injury.

A) Resident Assessments

In 2019, the Ministry of Health and Long-Term Care (MOHLTC) sent a memo to licensees which identified the Food and Drug Administration (FDA) "*Clinical Guidance for the Assessment and Implementation of Bed rails in Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003*" as a prevailing practice document to be used as a basis for assessing residents for risk related to bed rail use. As per the 2019 memo, and the FDA prevailing practice document, assessments are to be done by a formalized interdisciplinary team. As per the FDA prevailing practice document, the use of bed rails is to be approved by the interdisciplinary team.

At the time of the incident, the resident had quarter rails at the head of the bed in use. The home most recent "Bed Assessment Tracking Tool" sheet completed in 2019, indicated that the resident had no bed rails in use at that time under the "comment" column. There was no bed assessment for over several months.

Review of the resident's health care records indicated that the home's "Resident and Bed System Safety Assessment" was completed on an identified date. However, it was determined that the resident did not have an assessment using the home's "Resident and Bed System Safety Assessment" prior the identified date.

The resident's "Resident and Bed System Safety Assessment" was completed by a Registered Nursing Staff. The assessment included recommendations made by the Registered Nursing Staff, including that the resident required the use of two quarter side rails. The Registered Nursing Staff who completed the resident's assessment stated that their recommendations were discussed with a PSW who was working on that shift.

The DOC stated that the resident had bed rails in use since their admission. The "Resident and Bed System Safety Assessment" for all residents were solely completed by a Registered Nursing Staff during the night shift. The resident was not assessed using the licensee "Resident and Bed System Safety Assessment" form prior the

identified date, for bed rails usage risks. The DOC stated that the home does not have a formalized interdisciplinary team to assess residents for risk related to bed rail use as directed in the Ministry of Health and Long-Term Care (MOHLTC)'s memo sent to the sector in 2019 as well as the referenced FDA "*Clinical Guidance for the Assessment and Implementation of Bed rails in Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003*" prevailing practice document.

Review of the resident's plan of care in the PointClickCare (PCC) since the resident's admission, did not identify that the quarter side rails were used on the resident's bed system. The DOC validated that the resident's plan of care should have included the use of bed rails.

B) Bed System Evaluations

A "Bed Assessment Tracking Tool" sheet completed in 2019, for one of the units was provided by the Administrator. The sheet indicated that the resident had a specific brand of bed, and the resident assessment and bed system evaluation was completed.

The resident had another brand of bed at the time of the fall incident.

The Administrator and the DOC stated that the resident's bed was changed from another brand of bed at a certain time, but they were unable to identify the date.

The Administrator stated that the last bed system evaluation for the resident's bed was completed in 2019.

The Administrator was unaware if a bed system evaluation was completed on the other brand of bed for the resident, as they were unable to identify the date that the resident received it.

As such, it was determined there was a potential risk for the resident when the resident's bed system had not been evaluated since 2019 and the resident was not assessed where bed rails were used prior an identified date. Additionally, the resident's plan of care in the PCC did not indicate the level of staff assistance required for the resident related to bed mobility as indicated in the resident's Minimum Data Set (MDS).

Sources: Review of a resident's health care record, the "Resident and Bed System Safety Assessment", the "Bed Assessment Tracking Tool" sheet completed in 2019, and interviews with the Administrator, DOC and a Registered Nursing Staff.

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COMPLIANCE ORDER CO#001 PLAN OF CARE

NC#001 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 6 (4)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]
The Licensee has failed to comply with LTCH, 2007 s. 6 (4) Specifically, the licensee shall: -review and reassess all residents' health care records who require extensive assistance for personal care and bed mobility to ensure that the resident's current plan of care reflects the assessment documented in the Minimum Data Set (MDS) and the "Resident and Bed System Safety Assessment". -keep a list of all the residents identified in the review and document actions taken and any strategies implemented to ensure that there is collaboration in the assessment, development, and implementation of the residents' plan of care.

Grounds
The licensee has failed to ensure that the staff and others involved in the different aspects of care of a 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 (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. **Rationale and Summary** A resident's health care records indicated that the resident slid out of bed and sustained a fall from their bed. The resident was assessed and noted to have sustained an injury. The resident complained of pain during the assessment. A treatment was administered to the resident. The resident presented with a change in level of consciousness. A physician was notified about the resident's injury and change of condition. The physician ordered to continue to monitor the resident and not to transfer the resident to the hospital as the resident had a specific care directive. The resident passed away.

The resident's Minimum Data Set (MDS) quarterly assessment on an identified date, indicated that the resident had altered cognitive function. The resident was using side rails daily. The resident's care requirement related to bed mobility, toileting and personal hygiene were identified.

The "Resident and Bed System Safety Assessment" completed three days prior to the fall, indicated different information from the MDS assessment related to bed mobility, toileting and personal care. The assessment also indicated that the resident was considered a high risk for fall and the recommendations were discussed with one staff member who was working on that shift.

The resident's current plan of care indicated a different level of assistance required for bed mobility, dressing and personal care than the MDS assessment.

Two staff members stated that on the identified date, they had provided personal care to the resident, while the resident was in bed. The resident fell off the bed.

The Registered Nursing Staff who completed the bed assessment three days prior the resident's fall made the decision to complete the "Resident and Bed System Safety Assessment" for the resident due to change in the resident's behavior. The Registered Nursing Staff stated that the completed "Resident and Bed System Safety Assessment" was not discussed with a multidisciplinary team.

The DOC validated that there was some inconsistent information in the resident's health care records within the resident's Minimum Data Set (MDS), the current plan of care in the PCC, the "Resident and Bed System Safety Assessment" completed three days prior the resident's fall. The DOC stated that there was no communication between the identified Registered Nursing Staff and the management team after the "Resident and Bed System Safety Assessment" was completed. Moreover, the licensee did not have an interdisciplinary team related to an assessment of resident bed systems.

Consequently, there was a significant impact to the resident as the resident sustained a fall with injury when the licensee failed to ensure that the staff members and other involved in the different aspects of care collaborate with each other.

Sources: A resident's health care records including the resident's plan of care and interviews with PSWs, Registered Nursing Staff, DOC and the Administrator.

Joelle Philippon-Taillefer (211)

This order must be complied with by August 24, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a

written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.