Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

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Original Public Report

Report Issue Date May 30, 2022
Inspection Number 2022_1250_0002
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Bruyère Continuing Care Inc., 43 Bruyère Street Ottawa ON K1N 5C8

Long-Term Care Home and City
Élisabeth-Bruyère Residence, 75 Bruyere Street, Ottawa, On, K1N 5C8

Lead Inspector
Julienne Ngo Nloga (502)

Additional Inspector(s)

Inspector Digital Signature
Julienne N. Nloga
2022.06.13 10:46:47 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 26 to 29 and May 3, 2022.

The following intake(s) were inspected:

- Intake # 003148-22 (CIS # 2759-000002-22) related to fall resulting in transfer to hospital

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)

INSPECTION RESULTS

WRITTEN NOTIFICATION O.REG. 79/10 . 52(2)

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

The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

On an identified date, staff reported that a resident complained of pain during care. One staff noted that the resident pulled one of their hands away when touched. The resident's hand was swollen, and that staff administered a specified medication. A second staff documented five hours later that the resident's hand was swollen and discolored. A third staff documented eleven hours later that the resident's hand remained swollen and painful.

The home's Pain Management, Long-Term Care policy directs staff to assess all residents for pain at readmission from hospital and when pain is not relieved by initial interventions, using the Pain assessment in Point Click Care (PCC).

Review of the completed assessment in the PCC did not identify a completed pain assessment after the pain medication was administered and when the resident returned from hospital the next day.

Staff and management acknowledged that the assessment was not completed when the pain was not relieved with the Tylenol.

Sources: Resident's progress notes, eMar, home's Pain Management policy, assessment record in PCC, staff interviews. [502]

WRITTEN NOTIFICATION [O.REG. 246/22 S.102 (2) (B)]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control. [s.102 (2) (b)]

Specifically, the licensee failed to ensure that that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include, additional PPE requirements including appropriate selection application, removal and disposal [IPAC Standard: **9.1.f**].

Rationale and Summary

During the observation of a resident, the Inspector noted that a staff came out of the resident's room after providing care. That staff was observed to be wearing gloves, gown and N95 mask with no face shield. They remove the soiled gown and deposit it on top of a full linen cart. Another resident was observed pulling the same linen cart.

The inspector also noted that a second staff, who assisted the first staff with the transfer of the first resident with a mechanical lift to their wheelchair, was not wearing a gown or a face shield.

The sign at the identified resident's door indicated: "All staff and visitors: Routine practice and droplet and contact precautions that include gloves, gown, mask and eye protection".

During the interview, the staff told the inspector that the resident was newly admitted from a

home in covid-19 outbreak and the protocol was to wear full PPE as they were in droplet precaution. They indicated that the linen cart was full, and they were not able to place the soiled gown inside the linen cart. However, the staff acknowledged that they should have removed the PPE prior leaving the resident room and properly disposed the soiled gown inside the bin at the designated area.

The IPAC lead stated that when a resident is in droplet contact precaution due to covid-19, staff are required to wear gloves, gown, face shield and fit-tested N95 mask when entering the resident's room, and a signage was posted by the door as a reminder. The gown should be disposed properly in the linen and staff should replace the linen cart when it is half full. They acknowledged that the identified staff did not follow the IPAC protocol in place.

Sources: Inspector #502's observation. Interviews with staff and IPAC lead.[502]

WRITTEN NOTIFICATION O.REG. 246/22 S. 102. (7) 11

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

The licensee has failed to ensure that there was in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. [102. (7) 11.]

Specifically, the Licensee failed to ensure that the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as support for residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments. [IPAC Standard: 10.4.i]

Rationale and Summary

During the observation of a meal service on an identified date, the Inspector noted that residents, seated in two dining areas, who required assistance with meal, were not supported to perform hand hygiene prior to meals.

In separate interviews staff and DOC indicated that the residents on the identified dining areas, were cognitively impaired and displayed responsive behaviours. They were not able to rub their hands if alcohol-based hand sanitizer (ABHS) Purell was provided to them, as those residents were not following instruction. Soap and water were not practical in the dining room. Both staff acknowledged that the residents on the identified dining areas were not assisted to perform hand hygiene.

The DOC stated that one of the recommendations of Ottawa Public Health Unit (OPHU) during their visit was to use ABHS to assist the residents perform hand hygiene, but it was not implemented due to residents' responsive behaviours.

The IPAC lead indicated that staff were expected to assist residents perform hand hygiene before meals by using ABHS Purell mounted on the wall or portable bottles available in the dining room. The IPAC lead indicated that there was a hand hygiene pilot project for cognitively impaired residents, but it was not implemented in the home at the time of this inspection.

Sources: Inspector #502's dining room observation. Interviews with staff and DOC and IPAC lead. [502].

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.
(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.

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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.