Ontario

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

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: June 12, 2023	
Inspection Number: 2023-1250-0005	
Inspection Type: Complaint Critical Incident System	
Licensee: Bruyère Continuing Care Inc.	
Long Term Care Home and City: Élisabeth-Bruyère Residence, Ottawa	
Lead Inspector Linda Harkins (126)	**Inspector Digital Signature** Linda Harkins Digitally signed by Linda Harkins Date: 2023.06.12 14:08:18 -04'00'
Additional Inspector(s) Manon Nighbor (755)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29, 31, 2023 and June 1, 2, 6, 2023.

The following intake(s) were inspected:

- Intake: #00016389 -2759-000027-22 Unexpected death.
- Intake: #00017366 - IL-08874-OT Complaint related to responsive behavior of a specific resident.
- Intake: #00018461 -IL-09315-OT Complaint related to responsive behavior of a specific resident.
- Intake: #00019361 -IL-09651-OT Complaint related to responsive behavior of a specific resident.
- Intake: #00019607 -IL-09774-OT Complaint related to responsive behavior of a specific resident.

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

Medication Management
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, 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 had specific responsive behaviour food triggers secondary to their medical condition. It was identified that the resident became agitated, verbally, and physically abusive, when the specific food items were not available.

One of the resident's responsive behaviours food triggers was included in written plan of care. The Administrator and the Director of Care indicated that the resident's treatment was adjusted to allow the resident to have a couple of their preferred food items after care was delivered which was indicated in their written plan of care. A staff member stated that they only gave the resident one because of the resident's medical condition. This staff member did not follow the resident's written plan of care. The resident had responsive behaviours if only one was provided.

Staff members and several documented records confirmed that the resident's responsive behaviours were also triggered by the unavailability of another specific food item, which was not included in the resident's written plan of care. Staff members indicated that the resident was provided what food items were available. The resident's specific food items were not always available for the resident. The staff member stated they did not collaborate with the kitchen staff to ensure that the two specific food items, were available for the resident.

As such, lack of collaboration in the development and implementation of the resident's plan of care related to specific food item triggers impacted the management of the resident's responsive behaviours.

Sources: **Health Care record and interviews with staff [755]**

Ontario

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

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559