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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: January 23, 2024	
Inspection Number: 2023-1250-0010	
Inspection Type: Complaint Critical Incident	
Licensee: Bruyère Continuing Care Inc.	
Long Term Care Home and City: Élisabeth-Bruyère Residence, Ottawa	
Lead Inspector Joelle Taillefer (211)	Inspector Digital Signature Joelle Taillefer Digitally signed by Joelle Taillefer Date: 2024.01.29 09:54:17 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on December 18, 19, 20, 21, 2023, and offsite on January 2, 2024.

The following intake(s) were inspected:
Complaint:

- Intake: #00102488 related to falls prevention and safe and secure home.

Critical Incident Report (CIR):

- Intake: #00100851 - related to reporting and complaints.
- Intake: #00102122 - related to prevention of abuse and neglect.

The following Inspection Protocols were used during this inspection:

Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
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 (7)
Plan of care
Duty of licensee to comply with plan
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
A resident's current plan of care indicated to apply an identified Personal Assistance Service Device (PASD) when the resident was in their wheelchair.

On a date in 2023, Inspector #211 observed the resident sitting in a wheelchair in an area. The resident's identified PASD was not applied.

The next day, the resident was found in their room sitting, and lying back in their wheelchair without the identified PASD.

A Personal Support Worker (PSW) stated that the resident's PASD in the wheelchair was never applied since the resident's family member refused to have the identified PASD attached as it was too tight.

A Registered Nursing Staff stated that the Occupational Therapist was aware that the identified PASD was not applied because it was not long enough. The Registered Nursing Staff stated that the resident's family member refused the PASD being applied when the resident was sitting in the wheelchair.

The Director of Care (DOC) stated that the resident's PASD could be applied when the resident was sitting straight in the wheelchair, but the PASD could not be applied when the resident was in a lying position in the wheelchair.

The Occupational Therapist stated they were unsuccessful to find a longer PASD to replace the present PASD in the resident's wheelchair and confirmed that the resident's family member refused to have the PASD in the wheelchair applied.

As such, the staff members did not follow the care set out in the resident's plan of care to apply the identified PASD when the resident was in the wheelchair.

Sources: A resident's health care records and interviews with a Personal Support Worker, a Registered Nursing Staff, the DOC, and the Occupational Therapist. [211]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that a resident's provision of care that was set out in the plan of care related to focus rounding was documented in the task's intervention on an identified date and times.

Rationale and Summary:
A resident's progress notes on a date in 2023, indicated that the resident sustained an unwitnessed fall at an identified time from their chair in an identified area.

Inspector #211 reviewed the resident's "Documentation Survey Report" for a month in 2023, and it was noted that there was no documentation related to focus rounding for an identified date and times.

The "Focus Rounding" power point presentation to the Personal Support Workers (PSWs) indicated to perform hourly focus rounding to ensure residents' well-being and their safety. The "Focus Rounding" was to verify the 4 Ps and 1 S: pain, positioning, personal hygiene, personal possessions, security, and equipment.

The Administrator confirmed that the "Focus Rounding" under the Documentation Survey Report for the identified date and times was not documented.

By not documenting if the resident's "Focus Rounding" was provided during the identified date and times, there was potential risk that the resident's well-being and their safety were not monitored hourly.

Sources: A resident's "Focus Rounding" for an identified month in 2023, and interview with the Administrator.
[211]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure to immediately forward a written complaint to the Director concerning the care of a resident in the manner set out in the regulations.

Rationale and Summary:
A resident's Medication Administration Record (MAR) for a month in 2023 indicated to administer an identified medication at a specific time.

On a date in 2023, the licensee received a complaint letter from the resident's family member indicating that the identified medication was not administered in a competent manner by a Registered Nursing Staff. The letter indicated that the identified medication was administered during meal time and while receiving another identified therapy as this practice is contrary to the application for this medication administration.

The next day, the licensee forwarded the Critical Incident Report (CIR) related to the above complaint letter to the Director.

The Administrator confirmed that the written complaint letter concerning the care of the resident sent by a family member on an identified date in 2023, was not immediately forwarded to the Director.

As such, the licensee did not immediately forward to the Director the written complaint that was received on an identified date concerning the care of a resident in the manner set out in the regulations.

Sources: Reviews of a resident's family member written complaint letter, the Critical Incident Report (CIR) and interview of the Administrator.
[211]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246 / 22, s. 54 (2); O. Reg. 66 / 23, s. 11.

The licensee has failed to comply with their policy to ensure that when a resident has fallen, the resident was assessed, and a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for

falls.

In accordance with O. Reg. 246/22 s.11 (1) (b), the licensee of a long-term care home is required to ensure that when a resident has fallen, the resident was assessed, and the policy and procedure must be complied with.

Rationale and Summary:
Specifically, the staff did not comply with their current policy #CLIN CARE 33 LTC "Fall Prevention, Long-Term Care" under "POST-FALL MANAGEMENT" that indicated if the fall is unwitnessed, the registered nursing staff completes and documents a Neurological Assessment in the PointClickCare (PCC). The post-fall Neurological Assessment will be completed as follows:
-During post-fall assessment,
-Within 1 hour of the initial assessment if the resident is stable with no evidence of injury (if the resident is unstable or presents evidence of head trauma/injury please monitor closely and follow the instructions of the physician)
-Every shift for 48 hours or per physician recommendations.

On an identified date and time, a resident was found on the floor mat beside their bed without an injury.

The resident's Neurological Assessments were not completed as per their policy on the identified date in 2023, during the day shift, and the next two dates in 2023, during the night shift.

The Director of Care confirmed that the Neurological Assessments were not completed for the resident on the identified date in 2023, during the day shift, and the next two dates in 2023, during the night shift as indicated in their policy.

Consequently, as the resident's fall was unwitnessed on the identified date and time and the registered nursing staff did not complete and document the Neurological Assessment as indicated in their "Fall Prevention, Long-Term Care policy, there was a potential risk that any change in the resident's health condition would not been identified.

Sources: Review of a resident's health care records, the "Fall Prevention, Long-Term Care" policy, and interview with the DOC.
[211]

WRITTEN NOTIFICATION: Minimizing of Restraining

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 121 7.
Prohibited devices that limit movement
s. 121 7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

The licensee has failed to ensure that a transferring identified device was not used as a Personal Assistance Service Device (PASD) to prevent a resident from falling from their wheelchair.

Rationale and Summary:
The resident's current plan of care indicated to attach an uncommonly used device to the wheelchair as requested by the family member.

A Registered Nursing Staff stated that the resident's family member refused the identified PASD being applied when the resident was sitting in the wheelchair. The resident's family member requested to attach the uncommonly used device in a

certain manner on the resident to the wheelchair.

On a date and time in 2023, the resident was found sitting in the wheelchair in the hallway. The identified PASD was not applied. Nor was the uncommonly used device applied in a certain manner on the resident to the wheelchair. A Personal Support Worker (PSW) informed Inspector #211 and the Director of Care (DOC) that the uncommonly used device was applied in a certain manner on the resident to the wheelchair during the morning. The DOC informed the PSW that the uncommonly used device should not be used as a PASD.

As such, there was a potential risk of safety when the uncommonly used device was used on the resident in the wheelchair as this type of device must not be used as a PASD.

Sources: A resident's health care records, observation and interviews with a Registered Nursing Staff, a PSW and the DOC.
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