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

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Original Public Report

Report Issue Date: March 26, 2024
Inspection Number: 2024-1250-0001
Inspection Type: Complaint Critical Incident
Licensee: Bruyère Continuing Care Inc.
Long Term Care Home and City: Élisabeth-Bruyère Residence, Ottawa

Lead Inspector	Inspector Digital Signature
Julienne NgoNloga (502)	Julienne Ngo Nloga Digitally signed by Julienne Ngo Nloga Date: 2024.04.12 11:37:25 -04'00'

Additional Inspector(s)
Sarah Bradshaw (740814) was present throughout the inspection as an observer.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 29, 2024 and March 1, 4, 5, 6, 7, 8, 2024

The following intake(s) were inspected:
Critical Incidents System Report

- Intake: #00104975, (CI #2759-000015-23) and #00105181 (CI #2759-000016-23) related to alleged resident to resident abuse.
- Intake: #00106517, (CI#2759-000003-24) related to alleged staff to resident physical abuse.

Complaint

- Intake: #00107916 related to fall prevention management and skin and wound.

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of abuse

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

Rationale and Summary
A resident displayed physical responsive behaviours toward two separate residents on two different days in December 2023, resulting in injury. The identified intervention was not implemented at the time of the incidents.
The first residents' plan of care indicated a history of identified responsive behaviours which required a specified intervention during identified shifts for safety.

The home's investigation confirmed that the specified intervention was not in place on both occasions. Days after the incident, the second resident voiced concern related to the above incident.

Interviews with staff indicated they were aware the resident should not have been left unsupervised, and stated that they were not replaced when they left the resident for a period of time. The Director of Care (DOC) acknowledged that the resident was unsupervised at the time of both incidents.

The co-residents were at risk for abuse when the specified intervention was not implemented for an identified period of time

Sources: Resident's health care record, home's investigation notes, interviews with staff and DOC.
[502]

WRITTEN NOTIFICATION: Behaviours and altercations

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or

who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Rationale and Summary

A resident displayed a specified responsive behaviours. The resident's health care record and the home's investigation identified the following incidents:

On two occasions in December 2023, a resident exhibited responsive behaviours toward a co-resident resulting in injury. At the time of the incidents, the specified intervention was not in place.

On an identified date and time, the resident displayed specified responsive behaviours and a specified medication was administered with no effect. After few hours, the resident displayed responsive behaviours toward a staff member.
At the time of all three incidents, the resident's specified interventions were not in place

A day during the inspection, the resident was observed seated, unsupervised with co-residents in the small dining room with no staff present in the room.

Interviews with staff indicated that the resident did not have specified interventions in place at the time of all three incidents.

The Administrator acknowledged there were periods when the resident specified interventions could not be implemented due to staff availability.

By not consistently implementing the interventions, the risk of altercations between residents was not minimized.

Sources: Health care records, licensee investigation records, inspector's observations and interviews with staff, and the Administrator.
[502]

WRITTEN NOTIFICATION: Waste Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 93 (2) (c)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(c) removal and safe disposal of dry and wet garbage; and

In accordance with O. Reg 246 / 22 s. 11 (1) (b), the licensee is required to ensure that any policy and procedure developed and put in place was complied with.

Specifically, staff did not comply with the policy "Gestion des déchets incluant les déchets dangereux chimiques, pharmaceutiques et biomédicaux / waste management, including hazardous waste: chemical pharmaceutical and biomedical", dated February 24, 2024, which was included in the Accommodation Services programs.

Rationale and Summary
A day during this inspection soiled continence care products were on the floor of a resident's room, no staff were present at the time of observation.

On a specific date and time, a staff member was observed holding a soiled

continence care product when exiting a resident room.

The staff member reported they had left the soiled continence product on the floor after they provided personal care to the resident and had gone back into the room to pick up the soiled product off the floor.

In separate interviews, the Director of Care (DOC), Administrator, and Infection Prevention and Control (IPAC) Lead stated that staff are expected to place soiled continence care waste in appropriate containers at the point of care afterward and not to leave soiled continence care products on the floor.

As such resident's soiled continence products left on the floor in residents' rooms were not appropriately removed and disposed of.

Sources: Resident's health care records. Inspector's observation, interviews with staff, IPAC Lead, DOC, and Administrator.
[502]

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC)

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

The licensee has failed to ensure implementation of any standard or protocol issued by the Director with respect to infection prevention and control.

Specifically, under the Infection Prevention and Control (IPAC) Standard: 9.1 (f) where the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum, additional precautions shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal, and disposal.

Rationale and Summary:
On a specific date and time, a staff member did not wear per minimum additional Personal Protective Equipment (PPE) required for infection prevention and control standards during the provision of continence care to a resident.

The resident laboratory results confirmed the presence of an identified infection on a certain date. Signage posted at the resident's door indicated required routine practices - additional contact and directed staff to wear gloves, gown, and face mask during direct care.

The IPAC Lead indicated that staff were trained on temporary and permanent additional precautions. Staff were expected to follow the directions outlined on the contact precaution signage at the resident's door.

The failure of staff to wear gowns during direct care placed other residents at moderate risk for cross-contamination of infection.

Sources: Inspector #502 observations, review of resident's health record, and interviews with staff and IPAC Lead.
[502]