



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de
London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 21, 2018	2018_532590_0016	014855-18	Resident Quality Inspection

Licensee/Titulaire de permis

1230839 Ontario Limited
708 Wellington Street WALLACEBURG ON N8A 2Y6

Long-Term Care Home/Foyer de soins de longue durée

Brouillette Manor
11900 Brouillette Court TECUMSEH ON N8N 4X8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ALICIA MARLATT (590), CAROLEE MILLINER (144), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 7 - 10, 2018.

Critical Incident System #2301-000005-18/Log #020907-18 was related to prevention of abuse and neglect and was inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Environmental Supervisor, the Activities Director, the Resident Assessment Instrument Coordinator, a Pharmacist, one Registered Nurse, four Registered Practical Nurses, one Health Care Aid, four Personal Support Workers, one Support Services Worker, one Registered Practical Nursing Student, the representative of the Residents' Council, three family members and 14 Residents.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, policies and procedures relevant to inspection items, Family Council meeting minutes, Residents' Council meeting minutes, Professional Advisory Committee (PAC) meeting minutes and Medication Management process reviews.

During the course of the inspection, the inspector(s) observed dining and snack services, recreational activities, infection prevention and control practices, the provision of resident care including resident specific routines, staff and resident interactions, medication administration practices, medication storage areas, all resident home areas, the general maintenance and cleanliness of the home and the posting of required information.

The following Inspection Protocols were used during this inspection:

**Accommodation Services - Housekeeping
Contenance Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care**



During the course of this inspection, Non-Compliances were issued.

2 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Review of the home's medication incident reports for January, February and March of 2018, showed a medication incident which occurred on a specific date.

The medication incident report stated a Registered Staff member had administered a specific topical medication to resident #003 and further documented that the topical medication was 'found on resident's Rt. (right) flank area this morning –resident does not have an order for this medication.'

Review of the clinical record for resident #003 showed that the resident did not have an order for identified medication to be administered.

On, August 10, 2018, an interview was conducted with Administrator #100 who stated that resident #003 had received a medication that was not ordered for them and should not have received that medication.

The licensee had failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident. [s. 131. (1)]



Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

- s. 50. (2) Every licensee of a long-term care home shall ensure that,**
- (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
 - (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
 - (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
 - (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
 - (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #006 was admitted to the hospital, then readmitted to the home two days later in a specific month in 2018.



During stage one of the Resident Quality Inspection (RQI) on August 7, 2018, at 1439 hours, Inspector #115 observed that resident #006 had an area of impaired skin integrity.

During stage two of the RQI on August 8, 2018, at 1450 hours, Inspector #144 also observed that resident #006 had an area of impaired skin integrity.

The clinical record for resident #006 was reviewed by inspector #144. The skin and wound assessment for the resident dated the day after the residents' return from the hospital, included that the resident had an area of impaired skin integrity, however described the area differently than what was observed by the inspectors.

The clinical record did not include a skin and wound assessment and information related to the area of impaired skin integrity that was observed by inspector #115 on August 7, 2018, and inspector #144 on August 8, 2018.

In an interview Registered Nurse (RN) #105 advised the inspector that nursing personnel were required to report observations of resident's with impaired skin integrity to the RN or Registered Practical Nurse (RPN) and that a skin and wound assessment would be initiated.

A Personal Support Worker (PSW) #109 told the inspector that they worked in the same section on this date where resident #006 resided and that as of 0900 hours, they had not observed the area of impaired skin integrity. PSW #109 advised that the home's policy was for PSW's to report areas of impaired skin integrity to registered staff.

In an interview PSW #110 shared with the inspector that they worked in the same section where resident #006 resided and that they had not observed the skin impairment on the resident. The PSW said that if residents were observed with impaired skin integrity, PSW's were required to report their observation to registered staff.

In an interview RPN #111 told the inspector that PSW's were required to report incidents of resident's with impaired skin integrity to the RPN or RN and that the RN would complete a skin and wound assessment.

The clinical record for resident #006 included that RN #105 documented that resident #006 had complained of pain and swelling and that on assessment, slight swelling was noted.



In an interview RN #105 shared with the inspector that PSW #110 had reported that they observed that resident #006 had an area of impaired skin integrity. RN #105 further stated that during their assessment of resident #006's skin on a specific date, they had not seen the area of impaired skin integrity.

PSW #110 during an interview told the inspector that they had observed the area of impaired skin integrity on the resident at 0930 hours on this date and reported it to RN #105 before their break at 1340 hours.

On a specific date the RN #105 documented in the clinical record of resident #006 that the area of impaired skin integrity on the resident had specific measurements taken. RN #105 advised the inspector that the documented area of impaired skin integrity measurement was incorrect and that they would update the clinical record to include what the actual measurements were.

The next day, the clinical record for resident #006 had not been updated to include the correct measurement of the area of impaired skin integrity.

Administrator #100 shared with the Inspector that though the home's skin and wound care program was not explicit, it was their expectation that staff reported resident areas of impaired skin integrity to the RN and that a skin and wound assessment be completed.

The licensee had failed to ensure that a resident exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 21st day of August, 2018

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.