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: August 19, 2024	
Inspection Number: 2024-1062-0004	
Inspection Type: Post-Occupancy	
Licensee: 1230839 Ontario Limited	
Long Term Care Home and City: Brouillette Manor, Tecumseh	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 29, 30, 31, 2024

The following intake(s) were inspected:

- Intake: #00122438 - Post-Occupancy Inspection - Phase 2

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 22.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
22. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

The licensee failed to ensure that a resident's Power of Attorney (POA) received information concerning an event and that the person received that information immediately.

Rationale and Summary
Review of a resident's clinical records had indicated that a resident had an event and there was no documentation of the POA being notified.

During an interview with the Director of Care (DOC), they indicated the expectation would have been that staff notify the POA of the event and confirmed that staff had not notified the POA.

Not having had the person of their choice notified of the event could have had a potential negative outcome to the resident's plan of care.

Sources: Resident's clinical records and staff interviews.

WRITTEN NOTIFICATION: Bathing

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that a resident was bathed at a minimum of twice weekly by a method of their choice.

Rationale and Summary
During an interview with a resident, they had indicated they had not received a bath or shower in a long time.

Review of the resident's clinical records had not received their minimum of two baths per week.

During an interview with the DOC, they had indicated the expectation would have been that the resident receive a minimum of two baths per week and had not for periods identified.

Not ensuring the resident is bathed at a minimum of twice weekly could have had a potential negative outcome on their quality of life.

Sources: Resident Clinical records and staff and resident interviews.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital.

The licensee failed to ensure that a resident who had altered skin integrity received a skin assessment on their return from the hospital.

Rationale and Summary
A resident who was identified to have had altered skin integrity had been readmitted to the home and did not receive a skin and wound assessment.

Review of the home's written wound care program, stated in part; " Complete a Head to Toe Skin Assessment and a Braden Scale on residents to identify current skin integrity alteration and risk for altered skin integrity: Upon any return of the resident from hospital.".

During an interview with the DOC they indicated that the expectation would have been that a skin and wound assessment would have been completed on return from hospital and was not.

Not completing a skin and wound assessment for the resident on return from hospital placed them at further risk of deterioration in their altered skin integrity.

Sources: Resident's clinical records, the home's policy and staff interview.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated.

The licensee failed to complete weekly skin and wound assessments for a resident.

Rationale and Summary
A resident was identified with altered skin integrity and did not receive a weekly skin and wound assessment.

Review of the home's written wound care program, stated in part; "Reassess residents exhibiting altered skin integrity at least weekly.".

During an interview with the DOC they indicated that the expectation would have been that a skin and wound assessment would have been completed weekly and

was not.

Not completing a weekly skin and wound assessment for the resident placed them at a moderate risk of undetected deterioration in their altered skin integrity and a potential for a delay in treatment changes.

Sources: Resident's clinical records, the home's written wound care program and staff interview.

WRITTEN NOTIFICATION: Pain Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

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

Rationale and Summary
A resident was identified as having had pain. An intervention was initiated and documented as ineffective. No additional follow-up was documented at the time of the ineffective intervention.

During an interview with the DOC they indicated that an assessment should have

been completed after the initial intervention was documented as ineffective and the staff should have notified the physician or nurse practitioner for further review.

Not completing a pain assessment after the initial intervention did not relieve the resident's pain, placed the resident at risk of unmanaged pain and decreased quality of life.

Sources: Resident's clinical records and staff interview.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2).

The licensee failed to ensure that symptoms indicating the presence of infection were monitored every shift for a resident.

Rationale and Summary
A resident was diagnosed with an infection and a treatment was initiated.

During interviews with registered staff, they had indicated that infection monitoring

should occur at least once a day. One registered staff indicated that the resident's temperature is taken when the antibiotic medication was administered, but they had not completed any other infection assessment.

Review of the home's policy, did not provide clear direction on the frequency of infection monitoring.

The DOC indicated that the expectation would have been that infection monitoring should have been completed every shift and was not.

Not monitoring for infection symptoms every shift could potentially delay detection of worsening symptoms and delay treatment for the resident.

Sources: Resident's clinical records, the home's policy and staff interview.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that drugs were kept stored in a medication cart that was secured and locked.

Rationale and Summary
During an observation, a medication cup full of medications were left on the top of

an unattended medication cart. Residents were observed in the immediate area.

During an interview with a registered staff member they acknowledged that the medications should have been placed back inside of the locked medication cart prior to leaving the area and were not.

Not ensuring that medications were kept in a secured and locked medication cart placed residents in the immediate area at risk for potential consumption of medications not prescribed to them.

Sources: Observation and staff interviews.