

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: November 5, 2024

Inspection Number: 2024-1062-0005

Inspection Type:

Complaint
Critical Incident

Licensee: 1230839 Ontario Limited

Long Term Care Home and City: Brouillette Manor, Tecumseh

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 16-18, 2024 and October 21-24, 2024.

The following intakes were inspected:

- Intake #00124166 related to a complaint regarding continence care and food, nutrition and hydration,
- Intake #00125552 related to fall prevention and management,
- Intake #00127803 related to an outbreak,
- Intake #00128165 related to a complaint regarding plan of care; and
- Intake #00128859 related to prevention of alleged neglect.

The following intake was completed in this inspection:

- Intake #00126553 related to fall prevention and management.

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

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration

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Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
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

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 failed to ensure that care was provided to a resident as outlined in their plan of care.

Rationale and Summary:

The Ministry of Long-Term Care (MLTC) received a complaint concerning the plan of care for a resident.

In an interview with staff members, they acknowledged that care was not provided to the resident as outlined in their plan of care.

Failure to adhere to the plan of care for the resident compromises the resident's dignity, well-being, and comfort.

Sources: Plan of care; observations and interviews with staff.

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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 has failed to ensure that a resident was 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.

Rationale and Summary

A complaint was received regarding a resident not being bathed.

The bathing task record was reviewed and it was noted that the resident was not being bathed at a minimum, twice a week by the method of their choice.

Administrator stated that bathing was not completed.

The resident was put at risk when they failed to receive regular bathing in a consistent manner to meet their personal hygiene requirements.

Sources: Plan of care and interviews with staff.

WRITTEN NOTIFICATION: Bedtime and rest routines

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NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 45

Bedtime and rest routines

s. 45. Every licensee of a long-term care home shall ensure that each resident of the home has the resident's desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

The licensee has failed to ensure that a resident's rest routines were supported and individualized to promote comfort, rest and sleep.

Rationale and Summary

A complaint was received regarding a resident's rest routines not being followed.

Administrator acknowledged that the resident's rest routines were not followed when required by the plan of care.

Sources: Plan of care and interview with Administrator.

WRITTEN NOTIFICATION: Resident records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 274 (b)

Resident records

s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary

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Review of the bathing task record noted that the resident did not receive bathing at a minimum, twice a week by the method of their choice. There was no documentation for alternative bathing options.

Administrator acknowledged that the expectation of staff was to document bathing and that the resident's bathing task record was not accurate as it was missing documentation. A staff stated that residents were expected to be bathed whether by shower, bath, or bed bath twice a week and that the expectation was that the staff completing the bath/shower/bed bath should be documenting that care.

Sources: Plan of care and interviews with staff.