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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Amended Public Report (A1)

Report Issue Date November 9, 2022
Inspection Number #2022_1508_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Bruyère Continuing Care Inc

Long-Term Care Home and City
Résidence St Louis

Lead Inspector
[Manon Nighbor #755

Inspector Digital Signature
Manon Nighbor Digitally signed by Manon Nighbor Date: 2022.12.13 14:35:07 -05'00'

AMENDED INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect the editing of two sentences in the WN #004. The Complaint, Critical Incident System and Follow-Up inspection, inspection #2022_1508_0001 was completed on July 28, 2022.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 15-17, 20, 22-24, 27-30, July 6-8, 18-22, 25-28, 2022.

The following intake(s) were inspected:

Follow Up Order
Intake #002486-22 from inspection #2021_831211_0021, related to medication. Compliance due date August 29, 2022.

Complaints
Intakes #009817-22, #001021-22, #000858-22, #000395-22, #020143-21 related to personal care.
Intake #005052-22 related to fall prevention.

Critical Incidents System (CIS)
Intakes #009638-22 (CI #3013-000034-22) and #010735-22 (CI #3013-000040-22) related to unexpected deaths.
Intake #021176-21 (CI # 3013-000044-22) related to fall prevention.
Intake #008612-22 (CI #3013-000027-22), related to end-of-life care.
Intakes #004222-22 (CI #3013-000007-22), #020057-21 (CI #3013-000040-21), #019801-21 (CI #3013-000039-21) related to alleged physical staff to resident abuse.
Intake #020166-21 (CI #3013-000041-21) related to resident missing personal belonging.

The intake, #008090-22 was reviewed on June 14, 2022, with other intakes related to falls. The issues were inspected June 15-17, 20, 22-24, 27-30, July 6-8, 18-22, 25-28, 2022, under inspection #2022_1508_0001, intakes #021176-21, #009638-22, and #010735-22, with the following areas of non-compliance identified: CO related to LTCHA, 2007 s. 6 (10)(b)

The intake, #008014-22 was reviewed on June 14, 2022, with other intakes related to abuse. The issues were inspected June 15-17, 20, 22-24, 27-30, July 6-8, 18-22, 25-28, 2022, under inspection #2022_1508_0001, intakes #004222-22, #020057-21 and #019801-21, with the following areas of non-compliance identified: WN related to LTCHA, 2007 s. 24 (1) 1.

NOTE: A Compliance Order related to O. Reg. 246/22 s. 54(1) was identified in this inspection and has been issued in a concurrent inspection, #2022_1508_0002, dated September 12, 2022.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s.114 (3) (a)	2021_831211_0021	001	Manon Nighbor #755

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

- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Palliative Care
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Residents' Rights and Choices
- Safe and Secure Home
- Skin and Wound Prevention and Management

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INSPECTION RESULTS

NON-COMPLIANCE REMEDIED - INFECTION PREVENTION AND CONTROL

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 102. 2 (b)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control program was implemented related to Routine Practice and additional Precaution.

In accordance with the Additional Requirement under 9.1.(a) of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes dated April 2022, the licensee shall ensure at a minimum, evidence-based practices related to potential contact precautions transmission and required precautions.

A droplet and contact precaution sign was observed posted outside of a resident's room. Inspector observed a resident wandering into the room without personal protective equipment (PPE). The wandering resident was removed from the room, immediately, by a staff member.

A Registered Nurse (RN) stated that the room should have a contact precaution sign posted and not a droplet and contact precaution sign.

Later that day, the appropriate, contact precaution sign, was observed outside of the resident's room. The risk to the resident was low.

Date Remedy Implemented: June 22, 2022
Manon Nighbor #755

NON-COMPLIANCE - REMEDIED HOUSEKEEPING

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#002 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 93. (2), (a), (ii).

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, cleaning of the home, including, common areas, including floors.

The licensee has failed to ensure that the floor of a servery was clean.

During a meal, the floor of the dining area servery, was observed to be dirty in multiple areas from previous spills that had dried.

This was brought to the Vice President of Residential and Community Care and Programs' attention and the floor was cleaned that same morning. The risk to residents was low.

Date Remedy Implemented: June 15, 2022
Manon Nighbor #755

NON-COMPLIANCE - REMEDIED DOORS IN THE HOME

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#003 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 12. (1), 1, i.

The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked.

The inspector observed that a clean room where resident's clothing and some toiletries were kept, had a face cloth wedged between the lock mechanism and the frame of the door to prevent the door from locking. This was reported to the Residential and Community Care and Programs Vice President's attention. On the same day, the face cloth was removed, the door was locked. This was a low risk to residents.

Remedy Implemented: June 15, 2022
Manon Nighbor #755

WRITTEN NOTIFICATION - PLAN OF CARE

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

Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Rational and summary:
A resident was observed sleeping in their bed. A Personal Support Worker (PSW), then found the resident on their bedroom floor, breathing. When the RPN came to assist the PSW, they assessed that the resident was no longer responding, they called the RN for assistance. When the RN assessed the resident, the resident was found with absent vital signs. As per the home's policy related to code blue, the registered staff members did not perform cardiac pulmonary resuscitation (CPR). The RN called for assistance and a few minutes later the Nurse Practitioner (NP) pronounced the resident's death.

The resident's wishes for their advanced directive included directives for appropriate investigations and interventions that could be offered, including attempts to resuscitate (CPR) and transfer to acute care.

Staff members followed the licensee's policy related to code blue, therefore the resident did not receive CPR, as per their advance directives.

Sources:
Interviews with multiple staff members.
CLIN CARE 14 SLR- Code Blue: Residents, Staff, Visitors (SLR) Policy, effective 1997-11 and revised 2018-08.
Electronic health care record including progress notes, plan of care, medical directives, and death record.
Manon Nighbor #755

WRITTEN NOTIFICATION - PLAN OF CARE

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (1) (c)

The licensee has failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Rational and summary:
The resident had a history of falls. They fell and passed away the next day.

Staff members stated, that a specific fall injury prevention strategy was in place during the resident's fall. This fall prevention injury strategy was not indicated in the resident's written plan of care. By not having the strategy included in the resident's written plan of care, there

was a risk of staff not being aware of the strategy for the resident's fall prevention care, increasing their risk of injury.

Sources:
Progress notes, falls huddles, plan of care.
Interviews with multiple staff members.
Manon Nighbor #755

WRITTEN NOTIFICATION -INFECTION PREVENTION AND CONTROL

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102. 2 (b).

The licensee shall implement, any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Specifically, the IPAC Standard s. 9.1 states that the licensee shall ensure that Routine Practices are followed in the IPAC program. At minimum Routine Practices shall include proper use of PPE, including appropriate selection and application, of personal protective equipment (PPE).

Rational and Summary:
A staff member was observed coming out of a resident's room after providing care, that had droplet/contact precautions signage posted. The signage indicated that the following PPE were required: mask, gown, and gloves. The staff member was only wearing their N95 mask. The staff member confirmed that the resident was on contact/droplet precautions and said that they should have been wearing eye protection, mask, gown, and gloves.

Inspector observed another staff member going in a resident's bedroom. They were holding the resident's meal tray; they repositioned a chair by the resident's bed and proceeded to start feeding the resident. The signage indicated contact precautions were in place and the following PPE were required: gown and gloves. The staff member should have been wearing a gown and gloves and the staff member was only wearing their N95 mask.

Two staff members were not following PPE directives placing residents at risk of infection.

Sources:
Inspector's observations.
Resident's room signage and a staff member's interview.
Manon Nighbor #755

WRITTEN NOTIFICATION - SAFE AND SECURE HOME

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 5.

The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Rationale and Summary:
The inspector observed a resident, in their bedroom, sitting on a chair eating their lunch on their bedside table. A garbage container was placed to collect water from a ceiling leak, beside where the resident was sitting.

A Registered staff member shared that the leak started on the night shift and maintenance was notified at that time. They said that the resident required assistance to mobilize and occasionally would walk to and from their bathroom independently.
A maintenance staff member confirmed that the leak was from the air conditioning system. Another maintenance staff member said they had told the nursing staff to move the resident.

The garbage container and the wet floor caution signs were placed between the resident and their bathroom, beside where the resident sat for meals. This caused increased risk of fall to the resident and potential food contamination.

Sources:
Observations and interviews with multiple staff members.
Manon Nighbor #755

WRITTEN NOTIFICATION - REPORTING CERTAIN MATTERS TO DIRECTOR

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24 (1) 1.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
A staff member observed another staff member rubbing lotion on a resident's back. The resident told the PSW that they were hurting them and to leave them alone. The staff member did not stop immediately, they continued rubbing the resident's back. The staff member that witnessing the incident did not intervene.

Review of the Critical Incident System Report (CIS) showed that the alleged incident of abuse was reported to the Director three days after the staff member witnessed the alleged abuse. Six other staff members became aware of the incident, days prior to reporting the incident.

A Director of Care (DOC) acknowledged that staff did not report the alleged incident when they became aware of it.

There was moderate risk to the resident as they reported having been mistreated to multiple staff members, the days following the incident.

Sources:
Interview with a DOC.
Incident report, progress notes, plan of care, skin and wound assessments.
Manon Nighbor #755

WRITTEN NOTIFICATION - TRANSFERRING AND POSITIONING TECHNIQUES

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 36.

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Rational and Summary
A resident's plan of care indicated that the resident required two person assistance with their transfers. The pictograms from the resident's room, demonstrated two person transfer with either a belt or a lift. The resident was transferred to their bed by one PSW, there was not a second person to assist. During this transfer the resident incurred an injury. In their written statement, the PSW acknowledged that they transferred the resident without assistance.

A DOC, indicated that home's investigation confirmed the improper transfer by the PSW.

By transferring the resident without assistance of a second staff, the resident sustained an injury.

Sources:
Interview with a DOC.
Handwritten letters and emails from staff related to the improper transfer.
Manon Nighbor #755

COMPLIANCE ORDER CO#001 PLAN OF CARE

NC#010 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 6 (10)(b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee shall ensure that the resident is reassessed, and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

The licensee shall:

A. Specifically, identify any resident who best fits the following definition: a resident who is at high risk of falls, that requires assistance to ambulate but continues to transfer and walks without assistance to their bathroom.
B. Review and reassess three of the identified residents' fall prevention plans of care so that the interventions and strategies are effective and current.
C. Perform, two audits (bi-weekly) over a period of four weeks for the identified residents' plan of care reassessments when interventions were no longer effective or when their health status changed, increasing their risk for fall.
D. Document the audit results as well as the strategies implemented to effectively manage identified discrepancies to provide hourly rounds, continence care and fall prevention strategies.

Grounds

Non-compliance with: LTCHA, 2007 s. 6 (10)(b)

The licensee shall ensure that the resident was reassessed, and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan was no longer necessary

Rationale and Summary

A resident was admitted ambulating independently with minimal assistance. Within the next few weeks, the resident's condition deteriorated. The resident fell, sustained an injury resulting in surgery and subsequently passed away the next month. Prior to their fall, the following fall risk factors were noted in the resident's plan of care:

- The resident contracted an infection a month prior to their fall. They subsequently developed symptoms which continued for another couple of months.
- Presented with increased weakness.
- They required additional interventions which were initiated weeks prior to their fall.
- The resident was using a transfer aid which the Occupational Therapist (OT) recommended it be removed weeks prior to their fall.
- The Occupational Therapist (OT) recommended bedside equipment weeks prior to the resident's fall, to assist the resident, which was not implemented.

Weeks prior to their fall, the resident started to expressed concern to staff members about their health changes, which was affecting their independent transfers. Their plan of care required them to have two-person assistance with a transfer device. A registered staff member flagged a safety concern related to the resident's independent transfers, days prior to the resident's fall but did not implement any fall prevention strategies at that time.

A PSW stated that the resident was at high risk for falls. They stated that the monitoring rounds were hourly and they did not recall observing the bedside equipment.

The OT indicated that in consultation with the physiotherapist (PT), they recommended the removal of the transfer aid. They later shared that they could have sent a requisition to maintenance to ensure that the device was properly reinstalled. They also recommended bedside equipment and a transfer device.

The RN confirmed the resident's condition was deteriorating, they stated the resident's fall prevention plan of care should have included specific equipment, devices and fall prevention strategies.

A staff member confirmed the resident's continence care needs changed. The resident required the initiation of a treatment, and their continence care was not reassessed.

An RPN stated that the resident's continence care needs changed, and the recommended equipment was not implemented.

The resident continued to self-transfer and use the toilet independently without requesting for assistance. The RPN and RN did not reassess the resident after their toileting needs changed.

The resident had a near miss fall during their medical transfer, following a treatment. The fall prevention interventions in place were not reviewed to address the above identified fall risks. Considering the resident's ongoing health condition changes, there was a risk to the resident's safety when they continued to ambulate independently.

Sources:
Interviews with multiple staff members
Critical Incident System (CIS) report, fall assessments record, Post Fall Huddle, progress notes, plan of care, RIMS.
Julienne Ngo Nloga #502

This order must be complied with by December 23, 2022

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.