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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 17, 2024
Original Report Issue Date: July 11, 2024
Inspection Number: 2024-1508-0003 (A1)
Inspection Type: Critical Incident
Licensee: Bruyère Continuing Care Inc.
Long Term Care Home and City: Residence Saint-Louis, Ottawa

AMENDED INSPECTION SUMMARY

This report has been amended to reflect the LEAN report process:
- In NC #002, details of the elopement were removed to reflect the LEAN report process.
- In NC #004 the resident's number was corrected to reflect the resident that the concern was inspected.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3, 4, 5, 8, 9, 11, 2024

The following intake(s) were inspected:

- Intake: #00116065 - CIS #3013-000018-24 related to allegation of resident to resident abuse.
- Intake: #00116411 - CIS #3013-000019-24 related to allegation of resident abuse. resulting in injury.

- Intake: #00116625 - CIS #3013-000020-24 related to a missing resident resulting in injury.
- Intake #00117570 - CIS #3013-000023-24 related to a resident's fall
- Intake: #00116777 - CIS #3013-000021-24 reporting and complaints related to a resident's care.
- Intake: #00117195 - CIS #3013-000022-24 related to a resident's fall resulting in injury.

The following Inspection Protocols were used during this inspection:

Medication Management
Safe and Secure Home
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

AMENDED 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) 19. iv.

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:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that the personal health information of a resident was protected and kept confidential in accordance with the Personal Health Information Act.

Sources: Observation, interview with a staff member and the Administrator

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe and secure environment for a resident when they exited the home and were unaccounted for an extended period of time.

Sources: Video footage, review of a resident progress notes. MDS, and home's

investigation.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee has failed to ensure that nursing and recreational staff involved in the different aspects of care of a resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Sources: Minimum Data Set (MDS), Progress notes, plan of care, home's investigation notes. Interviews with two staff members

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) 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,

(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the falls interventions set out in the plan were not effective.

Sources: Record review care plan and interview with a staff member

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 59 (a)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

The licensee failed to ensure that steps were taken when factors were identified and documented by the staff to minimize the risk and potential harmful interaction between two residents.

Sources: Record review care plan and interview with staff members

WRITTEN NOTIFICATION: Behaviours and altercations

NC #006 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

The licensee has failed to ensure that procedures and interventions that were developed to assist a resident who was at risk of harm or who are harmed as a result of another resident behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents were implemented.

Sources: Review of resident's progress notes, care plan. Interview with staff members

WRITTEN NOTIFICATION: Medication Management

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 has failed to ensure that a medication cart was locked during medication administration pass on a resident's care area.

Sources: Observation and interview with staff members.