Ontario

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 1, 2017	2017_543561_0007	008734-17	Resident Quality Inspection

Licensee/Titulaire de permis

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive Georgetown ON L7G 2B8

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

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive Georgetown ON L7G 2B8

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

DARIA TRZOS (561), KATHLEEN MILLAR (527)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 4, 5, 8, 9, 10, 2017

Follow Up (FU) Inspection log number 002228-17 related to abuse and neglect was completed during this Resident Quality Inspection (RQI).
Critical Incident (CI) Inspection log number 000760-17 related to responsive behaviours was completed during this RQI.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Physician, Registered Dietitian (RD), Food Services Manager (FSM), Manager of Finance and Administration, Resident Resource Coordinator, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) Nurse, Housekeeping Aides, Dietary Aids, Personal Support Workers (PSWs), Recreation Coordinator, Resident Council President, Family Council President, residents and family members.

During the course of the inspection, inspectors also toured the home, observed the provision of care, reviewed health care records, and reviewed relevant policies, procedures and practices.

The following Inspection Protocols were used during this inspection:
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **6 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_449619_0032	561

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident’s care needs changed or care set out in the plan was no longer necessary.

Resident #011 was inspected as a result of a deterioration in health condition during the Resident Quality Inspection (RQI). The resident had a change in condition within one month in 2017 and this resulted in a significant change over the course of one year. The resident was non-verbal due to severe cognitive impairment.

The clinical record was reviewed and the resident was assessed by the Registered Dietitian (RD) as a high risk for the condition related to the disease process. The resident's food and fluid intake was decreasing each month and one of the months in 2017 resident also refused to eat and was not achieving their overall goal range. The Resident Assessment Instrument - Minimum Data Set (RAI-MDS) annual assessment was conducted, which did not identify the resident as end-stage disease. The written plan of care was reviewed and included the goals for resident and interventions for the health condition.

Resident #011 was observed on numerous occasions during the RQI and during some observations resident was refusing care.

The Registered Dietitian (RD) was interviewed and acknowledged that they were aware of resident's condition, family was aware and alternative were discussed.

Registered staff #101 was interviewed during inspection. The registered staff was involved in the interdisciplinary care conference and confirmed that family was aware of resident's condition. The registered staff also confirmed the process for referral to RD and that no referral was made when resident's condition changed.

The RD and registered staff #101 confirmed that the written plan of care did not reflect the current condition of the resident as it related to their needs, and the written plan of care was not reviewed and revised when the resident’s care needs changed. [s. 6. (10) (b)]

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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home’s policy titled "Non-Abuse Program”, reviewed and revised May 2016, stated "any staff/volunteer witnessing or having knowledge of an alleged/actual act of abuse or becoming aware of one shall immediately report it to his/her immediate Manager, the Director of Care or the CEO or designate. Upon becoming informed of an alleged act of abuse, the CEO or designate shall notify the Ministry of Health and Long Term Care immediately via Critical Incident Reporting System".

On an identified day in 2017 an allegation of abuse was reported to the home by a staff member.
The home did not report this alleged verbal abuse to the Director. The Director of Care (DOC) was interviewed and stated that they were in the process of the investigation and have not reported this incident to the Director. The DOC was also interviewed after the home had completed the investigation and the alleged abuse could not be confirmed, therefore, the incident was not reported to the Director.
The licensee failed to ensure that their Abuse and Neglect Policy was complied with in relation to reporting of alleged abuse to the Director. [s. 20. (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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the programs included, (a) the development and implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

Resident #011 was assessed by the RD on an identified day in 2017 as being a high risk, had a change in condition and decline in their condition. Resident was not achieving their goal as indicated in the plan of care.

The home's policy titled "Feeding and Hydration", section 14, and last revised January 2016, directed registered staff to monitor residents' intake and indicated that a certain amount of intake would be required for residents weighing less than 50 kg. Resident #011's weighed less than the requirement and consumed less per day than the requirement according to the policy during a specified month in year 2017.

The RD was interviewed and indicated that resident's intake was individualized and the policy for fluid intake was not based on the current evidenced-informed practices. The

RD further indicated that although they reassess the resident's nutritional and hydration status on a monthly and quarterly basis as per the risk assessment, that there was no formal process that guides registered staff when making referrals to the RD. The RD confirmed that they were not consulted in the development and implementation of the nutrition and hydration policies and procedures.

Registered staff #101 was interviewed, they indicated that the registered staff would review residents' food and fluid intake over a period of a week and in consultation with the physician to rule out any medical issues, then refer to the RD when there were concerns related to nutrition and hydration. Registered staff #101 confirmed that there was no formal direction or guidelines for registered staff to follow when making RD referrals.
The DOC was interviewed and confirmed that the RD was not consulted in the development and implementation of policies and procedures related to nutrition care and hydration. [s. 68. (2) (a)]

2. The licensee failed to ensure that the nutrition care and hydration programs included, (e) a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter, and (ii) body mass index and height upon admission and annually thereafter.

The LTCH Inspectors #527 and #561 identified during stage one of the RQI that a number of residents in the home had no annual heights completed in their clinical record. The home's policy titled "Resident Assessments and Vital Signs", last revised January 2016, directed the PSW staff to ensure that the residents’ height was obtained annually and the registered staff were responsible to ensure the information was documented in the resident’s electronic health record.

The "Current Weights and Vitals" report and the “Missing Entries Report” from Point Click Care were reviewed and they identified that twenty two residents out a total of sixty six (22/66) had no heights completed or documented in their clinical records since 2015.

PSWs #102 and #104 were interviewed and confirmed that they were expected to obtain the residents' height annually and the registered staff would document the information in the electronic health record. Registered staff #100 and the DOC confirmed that the residents were expected to have their heights obtained annually and this was not done according to the home’s policy and procedures.
The home did not ensure that all residents had their heights completed and documented

annually in their clinical records. [s. 68. (2) (e)]

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 the programs include, (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration, and to ensure that the nutrition care and hydration programs include, (e) a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter, and (ii) body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that they did seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

The Residents' Council meeting minutes were reviewed for the time period between November 2016 and April 2017. There was no evidence indicating that the Residents' Council was involved in developing and carrying out the satisfaction survey. The CEO of the home was interviewed and confirmed that the licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.
The licensee failed to ensure that they did seek the advice of the Residents' Council in developing and carrying out the satisfaction survey. [s. 85. (3)]

2. The licensee has failed to ensure that they did seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

The Family Council President was interviewed and indicated that the licensee did not

seek the advice of the Family Council in developing and carrying out the satisfaction survey last year. The President of the Family Council had provided documentation indicating that the last time the licensee involved the Council in developing and carrying out the satisfaction survey was in November 2015 and there was no response from the licensee to the recommendations. The CEO was interviewed and confirmed that the last time they had involved the Council in developing the satisfaction survey was in November 2015.
The licensee failed to ensure that they did seek the advice of the Family Council in developing the satisfaction survey. [s. 85. (3)]

3. The licensee has failed to ensure that they made available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

The Family Council President was interviewed and indicated that the home did not share the results of the satisfaction survey with the Family Council. The meeting minutes from the Family Council meetings between August 2016 and April 2017 were reviewed and there was no evidence that the satisfaction survey results were shared with the Council. The CEO was interviewed and confirmed that the results of the satisfaction survey were not shared with the Family Council.
The licensee failed to ensure that the results of the satisfaction survey were made available to the Family Council. [s. 85. (4) (a)]

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 the licensee seek the advice of the Residents' Council and the Family Council in developing and carrying out the satisfaction survey, and in acting on its results and to ensure that the results of the survey are documented and made available to the Family Council to seek their advice., to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The Nutrition and Hydration program was reviewed during the RQI.
The LTCH Inspector #527 identified non-compliance with respect to nutrition and hydration care. The LTCH Inspector #527 requested from the DOC a copy of the home's annual evaluation for the Nutrition and Hydration program for review and to ensure compliance.
On May 10, 2017, the DOC informed the LTCH Inspector #527 that the home did not complete the annual program evaluation in 2016 for Nutrition and Hydration and could not provide the inspector with a copy for review.

The home failed to ensure that the Nutrition and Hydration program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices; and there was no written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. [s. 30. (1) 1.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The Residents' Council President was interviewed during the RQI and indicated that they were not sure if the licensee responded to the concerns raised by the Council within 10 days. Meeting minutes from the Residents' Council meetings were reviewed for the period of time between November 2016 and April 2017. During the February 15, 2017 meeting, the Council had raised concerns related to management not being easily accessible throughout the day due to the amount of meetings being held and would have liked to see the management staff presence more throughout the building. The response was provided to the Council on March 22, 2017. The Assistant of the Residents' Council was interviewed and indicated that they had received the concern on February 16, 2017 and confirmed that the response was provided to the Council late. The CEO was interviewed and confirmed that the response to the concern raised by the Council was not provided in writing within 10 days of receiving it.
The licensee failed to ensure that they responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

Issued on this 5th day of June, 2017

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

Original report signed by the inspector.