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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
500 Weber Street North
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Telephone: (888) 432-7901
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500 rue Weber Nord
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 12, 2018	2018_723606_0021	023987-17, 005347-18, 026051-18	Critical Incident System

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

JANET GROUX (606), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 2, 3, 4, and 5, 2018.

The following intakes were inspected:
Log # 023987-17 Critical Incident (CI) #2816-000006-17 regarding an allegation of staff to resident abuse.
Log # 005347-18 CI #2816-000004-18 and log #026051-18 CI 2816-000009-18 regarding a resident fall resulting in an injury.

Please Note: A Written Notification and Compliance Order related to LTCHA, 2007, s.19 (1) were identified in this inspection for log # 023987-17 and have been issued in Inspection Report 2018_601532_0022.

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator, Director of Care (DOC), Physiotherapist (PT), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of this inspection, the inspector observed resident care, observed staff to resident interaction, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

1 WN(s)
0 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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	Légende 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. (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. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

A Critical Incident (CI) submitted to the Ministry of Health and Long Term Care (MOHLTC) reported that resident #003 fell and sustained a serious injury.

The CI report indicated that resident #003 was found on the floor and they told the staff that they had gotten up by themself. The CI indicated the resident had a history of self transferring.

Review of a fall incident report completed indicated two falls interventions, one of which was a falls prevention device to manage the resident's further risk of falling.

Resident #003's written care plan listed several interventions to manage the resident's risk of falling including an identified falls prevention device.

During the inspection, resident #003 was observed sitting in their wheelchair, and that their call bell was out of reach, and their falls intervention device was not in place.

Personal Support Worker (PSW) #108 who was assigned to provide care to resident #003 was uncertain if the resident was to have a specific falls intervention device.

The Resident Assessment Instrument (RAI) Coordinator #119 said that the specific falls intervention device should have been in place and was not.

The Director of Care (DOC) acknowledged that the resident's call bell and specific falls intervention device should have been in place and were not.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

B) A CI submitted to the MOHLTC reported an allegation of staff to resident abuse.

Review of resident #003 and #006’s clinical records stated that both residents were cognitively impaired and were identified to display responsive behaviours towards staff during care.

Resident #003’s written care plan directed staff to be patient and gentle, and to answer and explain the care being provided.

Review of resident #006’s written care plan identified the resident to display responsive behaviours during care and directed staff to stop care when the resident was displaying the responsive behaviours and re-approach when they had settled.

The CI reported two incidents of staff abuse towards resident #003 and resident #006. The first incident involved resident #006, which stated that while PSW #130 was providing care to resident #006, the resident displayed a responsive behaviour.

PSW #121 stated that PSW #130 provided care to resident #006 despite the resident's refusal to care.

For the second incident, the CI report stated resident #003 told PSW #130 that they were not ready to receive care and that PSW #130 insisted. PSW #121 witnessed PSW #130 provide care to resident #003 in an abusive manner.

PSW #121 stated resident #003 did not want care at the time and said this to them and PSW #130. PSW #130 insisted and provided care to resident #003 in a manner that was unacceptable.

PSW #130 stated that they were aware that when a resident was refusing care that the direction was to stop the care and resume when the resident allowed it. The PSW acknowledged that they did not follow the residents' plans of care.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the when the resident was being reassessed and the plan of care was being revised because care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care.

A CI submitted to the MOHLTC reported that resident #003 fell and sustained a serious injury.

One of the intervention stated in the CI stated that resident #003 was assessed for needing a particular equipment for their care but did not receive it until almost three months later.

The RAI Coordinator #119 revealed that different approaches were considered after the first time during the year when the resident #003 fell and sustained an injury. The RAI Coordinator said that the Falls Committee met weekly and reviewed all the resident falls that occurred from the previous week and that the residents' care plans were updated during the meeting.

There were no evidence of a fall meeting minutes to show that resident #003's was discussed during the month that they fell.

The RAI Coordinator reviewed resident #003's current care plan and acknowledged that no new interventions were trialed after the resident's first fall and that the resident had another fall three days later when they transferred on their own from their bed. The RAI Coordinator acknowledged that the plan of care was not revised until later in the month and different approaches were not considered after the second fall.

B) A CI submitted to the MOHLTC reported that resident #007 fell and sustained a serious injury.

Resident #007's incident report revealed that resident #007 was found on the floor and was admitted to hospital with a serious injury.

Resident #007's progress notes revealed that the resident had several falls during the year.

The home's falls meeting minutes for identified dates revealed that resident #007's previous fall incidents were discussed and identified the reason for the resident's falls with recommendations to manage the resident's further risk of falling.

Resident #007's written care plan identified the resident as a risk for falling and listed several interventions to manage the resident's risk. However, there was no evidence that other interventions were tried or put in place to manage the resident's multiple falls prior to this fall incident as recommended.

PSW #128 stated that resident #007 was at risk of falling because they would transfer by themself. RPN #129 stated that the resident was at risk of falling and confirmed that the resident has had several falls prior to the fall on an identified date and that there were no other interventions in place other than what was in the resident's care plan.

The DOC stated that the home's Fall Committee met weekly to discuss all resident fall incidents from the previous week and that resident #007 would have been discussed during the meeting and that there should have been some revisions in resident #007's care plan to address their risks of falling.

The licensee has failed to ensure that the when the resident was being reassessed and the plan of care was being revised because care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care. [s. 6. (11) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 2nd day of January, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANET GROUX (606), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2018_723606_0021
Log No. / No de registre :	023987-17, 005347-18, 026051-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 12, 2018
Licensee / Titulaire de permis :	Bennett Health Care Centre 1 Princess Anne Drive, Georgetown, ON, L7G-2B8
LTC Home / Foyer de SLD :	Bennett Health Care Centre 1 Princess Anne Drive, Georgetown, ON, L7G-2B8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brian Jackson

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To Bennett Health Care Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Order / Ordre :

The licensee must be compliant with s. 6(11) (b) of the Long Term Care Homes Act (LTCHA).
Specifically, the licensee shall ensure that different approaches related to falls prevention and management are considered in the revision of #003 and #007's plan of care and any other resident, when the plan of care is being revised because care set out in the plan has not been effective.

Grounds / Motifs :

1. The licensee has failed to ensure that the when the resident was being reassessed and the plan of care was being revised because care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care.

A Critical Incident (CI) submitted to the Ministry of Health and Long Term Care (MOHLTC) reported that resident #003 fell and sustained a serious injury.

One of the intervention stated in the CI stated that resident #003 was assessed for needing a particular equipment for their care but did not receive it until almost three months later.

Resident Assessment Instrument (RAI) Coordinator #119 revealed that different approaches were considered after the first time during the year when resident

#003 fell and sustained an injury. The RAI Coordinator said that the Falls Committee met weekly and reviewed all the resident falls that occurred from the previous week and that the residents' care plans were updated during the meeting. There was no evidence in the fall meeting minutes to show that resident #003 was discussed during the month that they fell.

The RAI Coordinator reviewed resident #003's current care plan and acknowledged that no new interventions were trialed after the resident's first fall and that the resident had fall three days later when they transferred on their own from their bed. The RAI Coordinator acknowledged that the plan of care was not revised until later in the month and different approaches were not considered after the second fall.

(532)

2. A CI submitted to the MOHLTC reported that resident #007 fell and sustained a serious injury.

Resident #007's incident report revealed that resident #007 was found on the floor and was admitted to hospital with a serious injury.

Resident #007's progress notes revealed that the resident had several falls during the year.

The home's falls meeting minutes for identified dates revealed that resident #007's previous fall incidents were discussed and identified the reason for the resident's falls with recommendations to manage the resident's further risk of falling.

Resident #007's written care plan identified the resident as a risk for falling and listed several interventions to manage the resident's risk. However, there was no evidence that other interventions were tried or put in place to manage the resident's multiple falls prior to this fall incident as recommended.

PSW #128 stated that resident #007 was at risk of falling because they would transfer by themself. RPN #129 stated that the resident was at risk of falling and

confirmed that the resident has had several falls prior to the fall on an identified date and that there were no other interventions in place other than what was in the resident's care plan.

The Director of Care (DOC) stated that the home's Fall Committee met weekly to discuss all resident fall incidents from the previous week and that resident #007 would have been discussed during the meeting and that there should have been some revisions in resident #007's care plan to address their risks of falling.

The licensee has failed to ensure that the when the resident was being reassessed and the plan of care was being revised because care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care.

The order was issued based on the following:
The severity of harm is level 3 actual harm/risk.
The scope is level 2 patterned.
The home's compliance history was level 2 which was one or more unrelated noncompliance in the last 36 months.
(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 07, 2019

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s.6(7) of the Long Term care Homes Act (LTCHA).
Specifically the licensee must ensure that the care set out in the plan of care is provided to residents #003 and #006 and any other resident as specified in the plan.

Grounds / Motifs :

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

A Critical Incident (CI) submitted to the Ministry of Health and Long Term Care (MOHLTC) reported that resident #003 fell and sustained a serious injury.

The CI report indicated that resident #003 was found on the floor and they told the staff that they had gotten up by themself. The CI indicated the resident had a history of self transferring.

Review of a fall incident report completed indicated two falls interventions, one of which was a falls prevention device to manage the resident's further risk of falling.

Resident #003's written care plan listed several interventions to manage the resident's risk of falling including an identified falls prevention device.

During the inspection, resident #003 was observed sitting in their wheelchair, and that their call bell was out of reach, and their falls intervention device was not in place.

Personal Support Worker (PSW) #108 who was assigned to provide care to resident #003 was uncertain if the resident was to have a specific falls intervention device.

The Resident Assessment Instrument (RAI) Coordinator #119 said that the specific falls intervention device should have been in place and was not.

The Director of Care (DOC) acknowledged that the resident's call bell and specific falls intervention device should have been in place and were not.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan

(532)

2. A CI submitted to the MOHLTC reported an allegation of staff to resident abuse.

Review of resident #003 and #006's clinical records stated that both residents were cognitively impaired and were identified to display responsive behaviours towards staff during care.

Resident #003's written care plan directed staff to be patient and gentle, and to answer and explain the care being provided.

Review of resident #006's written care plan identified the resident to display responsive behaviours during care and directed staff to stop care when the resident was displaying the responsive behaviours and re-approach when they had settled.

The CI reported two incidents of staff abuse towards resident #003 and resident #006.

The first incident involved resident #006, which stated that while PSW #130 was providing care to resident #006, the resident displayed a responsive behaviour.

PSW #121 stated that PSW #130 provided care to resident #006 despite the resident's refusal to care.

For the second incident, the CI report stated resident #003 told PSW #130 that they were not ready to receive care and that PSW #130 insisted.

PSW #121 stated resident #003 did not want care at the time and said this to them and PSW #130. PSW #130 insisted and provided care to resident #003 in a manner that was unacceptable.

PSW #130 stated that they were aware that when a resident was refusing care that the direction was to stop the care and resume when the resident allowed it. The PSW acknowledged that they did not follow the residents' plans of care.

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

The order was issued based on the following:
The severity of harm is level 3 actual harm/risk.
The scope is level 2 patterned.
The home's compliance history is level 4 which despite Ministry of Health (MOH) action (voluntary plan of correction (VPC), order), noncompliance (NC) continued with original area of NC.

(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 07, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of December, 2018

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Janet Groux

Service Area Office / Bureau régional de services : Central West Service Area Office