Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 21, 2020	2020_821640_0011	011341-20	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

HEATHER PRESTON (640)

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): June 18, 19 and 22, 2020.

During the course of the inspection, the Long-Term Care Homes (LTCH) Inspector toured the home, reviewed resident records, policy and procedure, observed the provision of care and conducted staff and resident interviews.

The following Critical Incident (CI) Report was reviewed:

Log intake #011341-20 related to fall of an resident with injury

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Director of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001, as specified in the plan.

Resident #001 was reviewed related to a Critical Incident (CI) report submitted by the home for a fall resulting in injury.

Resident #001 had been assessed at high risk of falling. They had multiple falls since admission to the home.

The Minimum Data Set (MDS) assessment assessed resident #001 to require limited assistance of one-person with physical assistance for walking.

The resident's plan of care directed staff to provide assistance as the resident was unsteady on their feet and at risk for falls.

During the inspection, the Long-Term Care (LTC) Homes Inspector observed the resident throughout the day to be walking with their walker about the hallways without supervision or assistance. One staff approached the resident to redirect them down toward their room but did not provide assistance to the resident. There were several staff in the area on all occasions.

RN #106 told the LTC Homes Inspector that the resident was unsteady on their feet, at high risk for falls and believed that staff were not directed in the plan of care, to provide assistance when the resident was walking. The entry in the plan of care and Kardex directed the PSWs to provide assistance when the resident was walking.

PSW #102 said that they believed the plan of care directed one person assist for walking and the resident used a walker. They said they did not often review the plan of care so were not sure.

The licensee failed to ensure that resident #001 was provided assistance for walking as specified in the plan of care [s. 6. (7)]

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 the licensee must ensure that the care set out in the plan of care is provided, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident received a continence assessment using a clinically appropriate assessment instrument specifically designed for the assessment of incontinence.

a) During a review of resident #001 related to the submission of a Critical Incident (CI) report related to a fall resulting in injury, it was identified that the resident had a number falls since their admission, several of which were during the night, many were in their bedroom between their bed and their washroom and they had been noted to be incontinent of urine.

The MDS assessment, assessed the resident to be moderately cognitively impaired. They required extensive assistance of one person for toilet use and limited assistance of one person for walking. They were assessed to be frequently incontinent of bladder. They had unsteady gait and had fallen with fracture.

The falls committee reviewed resident #001's falls and noted that the resident had needed to use the washroom, was found on the floor and had been incontinent.

RN #100 said that the home's Falls Management Program policy directed staff to implement an individualized, specific toileting plan, based on an assessment, for resident's who had fallen or were at risk for falling. They said that resident #001 did not have such a plan.

Review of the home's policy "Falls Management Program" with a revised/reviewed date of October 2019, directed that when a resident had fallen, staff were to implement immediate interventions to include increased toileting and to develop an individualized toileting plan based on an assessment.

RPN #101, the Continence Care Program Lead, said the home's clinically appropriate assessment instrument specifically designed for the assessment of continence, was the homes form "Resident Continence Assessment". They said this assessment had not been conducted for resident #001 and it was expected to have been completed.

b) Resident #002's MDS admission assessment, assessed the resident with moderately impaired cognition. They were assessed as incontinent of bowel and bladder.

The clinical record was reviewed and there was no “Resident Continence Assessment” completed. RPN #101 said the assessment had not been conducted and it was expected to have been.

The licensee failed to ensure that residents #001 and #002 received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (a)]

2. The licensee failed to ensure that residents #001 and #003 had an individualized plan to promote and manage bladder continence that was based on an assessment.

a) Resident #001 was reviewed related to a Critical Incident (CI) report submitted by the home for a fall resulting in injury.

The LTCH Inspector reviewed the falls the resident had sustained since admission. Several of the falls occurred on the night shift. Many were in the resident's room between their bed and their washroom. They had been noted to be incontinent of urine.

MDS assessment, assessed the resident to be frequently incontinent of bladder. They were assessed to be at high risk for falls.

RN #106 said that the home's Falls Management Program policy directed staff to implement an individualized, specific toileting plan for resident's who had fallen or were at risk for falling. They said that resident #001 did not have such a plan.

The licensee's policy "Falls Management Program" with a review/revised date of October 2019, directed staff to immediately implement interventions to prevent further falls such as; toileting with specified frequency, increased assistance targeted for specific high-risk times, increased monitoring using sensor devices or alarms and increased staff supervision as some examples. The policy directed staff to implement an individualized toileting plan and to assess the resident for bowel and bladder program to decrease urgency and incontinence.

The licensee's policy ""Bowel and Bladder Management Program", with a reviewed date of January 2018, directed staff to observe the resident for seven days and document the times of voiding on the voiding record to determine the times the resident usually voids. Staff were to develop a resident specific schedule for toileting prior to the typical voiding times to prevent incontinence. These details were to be documented in the care plan. The PSW was to toilet the resident at the specific times and document the results. The RN/RPN were directed to review the outcome of the toileting plan and adjust as required.

Following admission, resident #001 was observed for seven days by the PSWs, and their toileting patterns were documented on their electronic documentation tool, "Voiding Record".

The clinical record was reviewed and there was no assessment of the voiding record to determine the resident's usual patterns of voiding.

RN #100 said they believed it was the Charge Nurse's responsibility to review the voiding record and implement an individual plan to manage continence and to enter that into the resident's plan of care.

PSW #102 and RN #100 said that resident #001's plan of care did not include an individualized plan to manage their continence.

b) The Long-Term Care Homes (LTCH) Inspector reviewed the multiple falls that resident #003 had sustained since admission. The majority were in their bedroom. Most were un-witnessed and they were noted to be incontinent.

MDS assessment, assessed the resident to be frequently incontinent of urine. The resident was assessed to be at high risk for falls since their date of admission.

Following admission, the resident was observed for seven days by the PSWs, and their toileting patterns were documented on their electronic documentation tool, "Voiding Record". The document identified when the resident was checked, assessed, was toileted and whether they had voided.

The clinical record was reviewed and there was no assessment of this voiding record to determine the resident's usual patterns of voiding.

The plan of care directed staff that the resident required assistance from one staff for regular toileting. Toilet upon waking, after breakfast. before lunch, before dinner and at bed time.

The LTCH Inspector reviewed the voiding record which identified the resident was wet or voided during toileting at common times of the day, evening and night.

The PSW said they had their own toileting plan for the resident as the plan of care did not have particular times.

The licensee failed to ensure that residents #001 and #003 had an individualized plan to promote and manage their continence as part of their plan of care. [s. 51. (2) (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 the licensee must ensure that;
a) all residents receive a continence assessment using a clinically appropriate assessment instrument specifically designed for the assessment of incontinence and,
b) residents who are incontinent have an individualized plan, based on an assessment, to promote bladder continence., to be implemented voluntarily.

Issued on this 23rd day of July, 2020

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

Original report signed by the inspector.