

**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**Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015Bureau régional de services de Centre
Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015**Public Copy/Copie du rapport public**

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 17, 2021	2021_781729_0015	004594-21, 007118-21	Critical Incident System

Licensee/Titulaire de permisBennett Village
1 Princess Anne Drive Georgetown ON L7G 2B8**Long-Term Care Home/Foyer de soins de longue durée**Bennett Centre Long Term Care
1 Princess Anne Drive Georgetown ON L7G 2B8**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

KIM BYBERG (729)

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): April 30, May 3, 5 - 6, 2021.

The following intakes were completed within the critical incident (CI) inspection:

**Log #004594-21,
Log #007118-21, both related to a resident being transferred to hospital due to an injury and experiencing a significant change in condition.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse, Fall Prevention Lead, Behaviour Support Lead, Housekeeping, Infection Prevention and Control Lead, Recreation Coordinator, Personal Support Workers (PSW), and residents.

During this inspection, inspector(s) toured the home, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures, and observed the general maintenance, cleanliness, safety and condition of the home.

This inspection was completed concurrently with complaint inspection #2021_781729_00014.

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

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

O. Reg. 79/10, s. 107 (4).

2. A description of the individuals involved in the incident, including,

i. names of any residents involved in the incident,

ii. names of any staff members or other persons who were present at or discovered the incident, and

iii. names of staff members who responded or are responding to the incident.

O. Reg. 79/10, s. 107 (4).

3. Actions taken in response to the incident, including,

i. what care was given or action taken as a result of the incident, and by whom,

ii. whether a physician or registered nurse in the extended class was contacted,

iii. what other authorities were contacted about the incident, if any,

iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and

v. the outcome or current status of the individual or individuals who were involved in the incident.

O. Reg. 79/10, s. 107 (4).

4. Analysis and follow-up action, including,

i. the immediate actions that have been taken to prevent recurrence, and

ii. the long-term actions planned to correct the situation and prevent recurrence.

O. Reg. 79/10, s. 107 (4).

5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to inform the Director of the immediate and long term actions planned to prevent the recurrence of falls for a resident within ten days of becoming aware of an incident that resulted in injury to them and for which they were taken to the hospital and developed a significant change in condition.

A critical incident report (CI) was submitted to the Ministry of Long Term Care. It stated that a resident had a fall which required medical treatment in hospital and resulted in a significant change in their condition.

The home did not update the CI to include the immediate and long term actions that were planned to prevent recurrence of falls for the resident.

Sources: CI #2816-000001-21, Interview with the DOC. [s. 107. (4)]

Issued on this 18th day of May, 2021

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

Original report signed by the inspector.