



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de
Hamilton
119 rue King Ouest 11^{ième} étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 24, 2015	2015_189120_0070	H-002491/2492/2997- 15	Follow up

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 19, 2015

A complaint inspection was also completed concurrently with this follow-up inspection related to a flooring project.

A follow-up inspection (2015-189120-0033) was previously conducted on April 23, 2015 at which time 2 Orders were issued related to bed safety and maintenance of bed systems. For this follow-up visit, the conditions laid out in the Orders were met, with the exception of one condition identified below.

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator, Director of Care and Resident Care Coordinator, toured the home and observed resident bed systems, reviewed bed maintenance audits, bed maintenance policies and procedures and resident clinical bed rail safety assessments.

**The following Inspection Protocols were used during this inspection:
Safe and Secure Home**

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

2 WN(s)

1 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 # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #002	2015_189120_0030		120
O.Reg 79/10 s. 90. (2)	CO #001	2015_189120_0030		120

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
<p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</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. 15. Bed rails



Specifically failed to comply with the following:

- s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
- (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
 - (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
 - (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the resident.

Based on a review of the licensee's clinical bed safety assessment tools and a discussion with the Director of Care and Resident Care Coordinator, residents were not fully assessed in accordance with prevailing practices adopted by Health Canada in a document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003" developed by the US Food and Drug Administration.

Residents were determined to have been assessed for their bed rail use needs for either mobility, transfers or repositioning and whether they were at risk of falling out of bed. A decision tree titled "Side Rail and Alternative Equipment Decision Tree" was used to evaluate each resident and the conclusion transferred to the resident's plan of care. The licensee's decision tree however did not include several components identified in the clinical guidance document. It was missing a written component to identify whether the resident was given alternatives to a bed rail, whether the alternatives were successful, how long the alternatives were used for and an evaluation of any safety risks (entrapment risks and other safety risks) when a bed rail was to be used. [s.15(1)(a)]



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

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 where bed rails are used, that residents are assessed in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 305. Construction, renovation, etc., of homes

Findings/Faits saillants :

1. s.305

(1) A licensee of a long-term care home shall not commence operation of the home under a new licence or approval until the Director has approved the home and its equipment.

(2) A licensee shall not allow alterations, additions, renovations, maintenance or repairs to be made to the home or its equipment that do not maintain or improve upon the functional aspects of the home or equipment.

(3) A licensee may not commence any of the following work without first receiving the approval of the Director:

1. Alterations, additions or renovations to the home.
2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents.

(4) A licensee who is applying for the Director's approval under subsection (3) shall provide the Director with,

- (a) plans or specifications relating to the work to be done; and
- (b) a work plan describing how the work will be carried out, including how residents will be affected and what steps will be taken to address any adverse effects on residents.

1. The licensee did not apply for the Director's approval prior to the start of renovations that were completed in the home as identified under subsection (3) above. The licensee did not provide the Director with plans or specifications relating to the work to be done and a work plan describing how the work was to be carried out, including how residents were to be affected and what steps were to be taken to address any adverse effects on residents as required in subsection (4).

During the week of July 22, 2015, floor tiles were removed and replaced to rectify cracking and pitting over a 4 day period within the home. The areas affected included the nurse's station, around the nurse's station, corridor leading to the dining room, in front of one of the dining room entrances and a portion of the corridor leading to the nurse's station from the main entrance. According to the Assistant Administrator, the work was completed in phases so that access to the dining room was always maintained and the work area was cordoned off to residents and visitors for safety. The Assistant Administrator confirmed that they were not aware of the requirement to submit any plans to the Director for this project. [s. 305.]



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 24th day of August, 2015

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

Original report signed by the inspector.