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

Division des foyers de soins de longue durée
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
Jan 9, 2017	2016_449619_0032	032843-16	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

SAMANTHA DIPIERO (619), DARIA TRZOS (561)

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): November 23, 24, 25, 28, 29, 30, 2016, and December 1, 2016.

The following complaint inspections were done concurrently with this Resident Quality Inspection:
log # 000066-16 related to personal support services
log #027502-16 related to falls prevention and the minimizing of restraining
log #030508-16 related to the prevention of abuse and neglect and missing personal property

The following critical incident inspections were done concurrently with this Resident Quality Inspection:
log #001538-16 related to falls prevention and lifts and transfers
log #008518-16 related to the prevention of abuse and neglect
log #020314-16 related to falls prevention

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Resource Coordinator (RRC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Recreation Aide, Dietary Aide, Physiotherapist (PT), Registered Dietitian (RD), Administrative Assistant (AA), residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

- **10 WN(s)**
- **9 VPC(s)**
- **1 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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to ensure that a resident was protected from abuse by anyone.

On an identified date in March 2016, resident #011 was displaying an unmanaged, ongoing responsive behaviour. Interview with resident #011 indicated that they complained to PSW #111 about not assisting a co-resident, and was admonished by PSW #111 for doing so. PSWs #109, #110, and #112, other residents, family, visitors, and volunteers witnessed PSW #111verbally abuse the resident. Interview with resident #011 indicated that PSW #111 physically abused the resident. Resident #011 stated that the physical abuse caused them to experience pain and experience fear and anxiety.

Interviews with PSWs #109, #110 and #112, as well as dietary aide #107 indicated that these staff were present in the dining room when PSW #111 verbally and physically abused resident #011. All staff present stated that they did not witness the physical abuse but witnessed the verbal abuse, and that none of these staff members intervened to stop the verbal abuse as it occurred. PSW #110 stated "I just put my head down and focused on my resident". PSW #111 was removed from the area by the home's Administrator after continuing to argue with the family member of another resident.

A review of PSW #109, #110, #111, #112, and dietary aide #107's training history indicated that the staff members had completed the home's anti- abuse training for the 2016 calendar year. A review of PSW #111's disciplinary history in the home indicated that PSW #111 was previously disciplined and was no longer employed by the home.

The home's policy titled, "Abuse and Neglect Prevention Program", last revised January 2016, stated that, "Residents of the facility have the right to be free from any form of abuse, neglect, or violence that could threaten their physical or mental well-being". Interview with DOC confirmed that the resident was not protected from abuse by PSW #111 in that, this staff member physically and verbally abused resident #011, and by staff members #107, #109, #110, and #112 for not intervening to protect the resident from abuse. [s. 19. (1)]

Additional Required Actions:

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

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 :

The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

The health care records were reviewed for resident #041 and it was identified that the resident had a history of falls. One of the strategies to prevent injuries was the implementation of a specified intervention; this was documented in the falls committee meeting minutes which occurred on an identified date in July 2016, and the intervention was noted as being in place on a second identified date in July 2016. Resident #041 was observed in bed on an identified date in November 2016; the intervention was not in place. Interview with PSW #118, who provided direct care to the resident, indicated that the resident did not require the specified intervention. On review of the resident's written plan of care, the use of the specified intervention was not included in the written plan of care for the resident. The DOC was interviewed and confirmed that the resident required the intervention at all times while the resident was in bed as part of the resident's falls prevention interventions and confirmed that the written plan of care did not set out the planned care for the resident. [s. 6. (1) (a)]

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

1. Resident #012's health care records indicated that resident had a fall on an identified

date in March 2016, and sustained an injury. The plan of care identified that the home's physician had ordered a diagnostic imaging test on an identified date in March 2016, and also ordered a referral to the physiotherapist to assess the resident's mobility. A review of resident #012's health records the physiotherapy referral could not be located. The interview with registered staff #103 indicated that the physiotherapist referral was not done. Interview with the Physiotherapist confirmed that they had not received a referral to assess mobility after the resident's fall on an identified date in March 2016. The licensee failed to ensure that the care set out in the plan was provided to the resident as specified in the physician order.

2. The current plan of care for resident #041, identified that the resident was to be transferred back to bed after meals to prevent them from going to their room and attempting to self-transfer to bed. It was identified that previous falls for this resident had usually been from attempting to self-transfer into bed. Resident #041 was observed on an identified date in November 2016, in their room watching TV. Interviewed the PSW #118 who provided direct care to the resident and stated that the resident did not fall anymore and was safe to sit in the room without supervision. The DOC was interviewed and indicated that the staff should be aware of the contents of the resident's written plan of care and should follow the resident's written plan of care. The DOC confirmed that resident #041 was at high risk for falls and should have not been left alone in the room in the chair.

3. The resident #041's health care records indicated that the resident sustained a fall from bed on an identified date in July 2016. The plan of care, at the time of the fall, identified that the resident required to have two specified falls prevention devices in place. The post fall assessment dated July 2016, indicated that one device was not applied because it was broken at the time of the resident's fall. The PSW staff that worked on that shift could not be interviewed. The DOC indicated that the staff should have ensured that the staff should have notified maintenance right away of the falls prevention device in disrepair. The Administrative Assistant who was responsible for maintenance was interviewed and indicated that they did not receive a request for maintenance for the broken falls prevention device prior to resident falling. The maintenance log was reviewed and the request for repair was not submitted for the broken falls prevention device. The device was fixed after the resident fell out of bed. The DOC confirmed that the staff failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan in relation to fall prevention. [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 with s. 6(7) where every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: 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 :

Without in any way restricting the generality of the duty provided for in section 19, the licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

On an identified date in March 2016, resident #011 was physically and verbally abused in the presence of co-residents, visiting family members, and staff by PSW #111. Interviews with PSW's #109, #110, and #112, and dietary aide #107, indicated that they witnessed PSW #111 verbally abusing resident #011. PSW #110 indicated that the verbal abuse made them feel "uncomfortable", and PSW #109 stated that they "put their head down and concentrated on their resident". Interview with RN #104 indicated that all staff who had received training on the home's abuse policy were expected to intervene and stop the act if a resident is being abused in any way. A review of the home's policy titled "Abuse and Neglect Prevention Program ", last revised January 2016, stated that the home has a "Zero Tolerance Policy" for abuse, and that "All staff members, associates, partners, and volunteers who witness or suspect the abuse of a resident are required to report the matter immediately." Interview with DOC confirmed that it is an expectation that when staff witness or suspect an abuse has occurred, they are required to intervene immediately to stop the abuse and protect the resident, as long as it is safe to do so, and confirmed that the home's staff did not comply with the home's zero tolerance abuse policy. [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 with s. 20 where 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

1. Resident #043 had an assisted fall. The progress note created on an identified date in November 2016, indicated that the resident stood up and upon attempting to sit, missed their seat and was assisted to the floor by a PSW. The LTC Inspector observed four staff members manually lift the resident off the floor and onto the chair, and did not observe staff assess the resident prior to manually lifting the resident off the floor. The plan of care for resident #043 was reviewed and indicated that the resident required a mechanical lift for all lifts and transfers. The interview with registered staff #104 confirmed that the resident required a mechanical lift for transfers and should have been lifted off the floor using a mechanical lift. The DOC confirmed that the staff should have used a mechanical lift to lift the resident from the floor. The licensee failed to ensure that staff used safe transferring techniques when assisting this resident.

2. Resident #042 sustained a fall on an identified date in January 2016, that resulted in injury. The plan of care for resident #042, in effect at the time of the injury, stated that resident #042 required a device to be applied while seated in the wheelchair. The interview with the PSW #116 indicated that resident was in the chair during transport; however, the safety devices were not applied to the chair. PSW #116 stated that they turned their back away from the resident for a second and the resident fell out of the chair. The investigation notes and the interview with the DOC confirmed that PSW #116 did not apply the safety devices as required which resulted in a fall with injury for resident #042. PSW #116 was disciplined for neglecting to apply the safety devices as required and for leaving the resident unattended, by turning their back with attention away from the resident. The licensee failed to ensure that staff used safe transferring and positioning devices when assisting residents. [s. 36.]

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 with r. 36 where every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

1. Resident #011 was physically and verbally abused by PSW # 111 on an identified date in March 2016. An area of resident #011's body was pushed down by PSW #111 forcefully causing pain and injury to the resident. In an interview resident #011 stated that PSW #111 tried to hit resident with the resident's own hand. Interview with RN #104 indicated that when there is a change in a resident's skin condition, including new altered skin integrity, that a skin and wound assessment form should be completed. A review of the home's internal investigation notes indicated that RPN #113 conducted an assessment on the resident on an identified date in March 2016, noted that the resident had a new alteration in their skin condition. This assessment was recorded in an e-mail that was sent to the DOC; the home's electronic, comprehensive skin and wound assessment tool was not employed. A review of the resident's health record indicated that a skin and wound assessment with the use of a clinically appropriate assessment tool was not completed. Interview with DOC confirmed that the resident did not receive a physical assessment on an identified date in March 2016, the day in which the resident was abused by PSW #111, and that the resident's altered skin integrity was not assessed with the use of a clinically appropriate assessment instrument.

2. Resident #042 sustained a fall on an identified date in January 2016 resulting in injury. The health care records indicated that upon return from the hospital the resident had a change in the skin condition on two separate areas. The interview with the wound care nurse #115, indicated that the staff were expected to assess the resident's skin and complete a head to toe assessment when the resident sustained an injury after the fall. In review of the health care records the skin assessment or the head to toe assessment could not be found. The registered staff # 113 confirmed that a skin assessment using a clinically appropriate assessment instrument designed for skin and wound assessments was not completed when the resident sustained injury from the fall. [s. 50. (2) (b) (i)]

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 with r. 50(2)(b)(i) where Every licensee of a long-term care home shall ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

Resident #007 was admitted to the home on an identified date in 2016. The Minimum Data Set (MDS) quarterly assessment dated in February 2016, indicated that the resident was frequently incontinent of bladder and occasionally incontinent of bowels. Interview with registered staff #114 and #115 indicated that upon admission, each resident receives a continence assessment using a clinically appropriate assessment tool in paper format and should be included in the resident's chart. The resident's health care records were reviewed and a continence assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of continence could not be found. Interview with the registered staff #113 who was the lead for the continence program in the home confirmed that a continence assessment was completed and included in the resident's written plan of care upon admission; however, a clinically appropriate assessment instrument was not used. [s. 51. (2) (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 with r. 51(2)(a) where 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, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that a resident with a weight change of 10 percent (%) of body weight over six months was assessed using an interdisciplinary approach, and that actions are taken and outcomes were evaluated:

Resident #006 was identified as a nutritional risk on admission to the home related to meal time responsive behaviours. A review of the resident's weight history for a six month period indicated that the resident sustained significant weight loss over a period of six months. Interview with RN #104 indicated that when a weight loss of 10% or greater within a six month period occurs, registered staff are required to submit a referral to the home's Registered Dietitian for an interdisciplinary team assessment. A review of the resident's nutrition and hydration assessments indicated that a referral to the Registered Dietitian (RD) was not completed. Interview with RD stated that the in the six month period the resident was treated with a medication to treat a chronic medical condition that could have caused the resident to lose weight, and confirmed that they did not receive a referral in relation to the resident's significant weight loss. Interview with DOC confirmed that the registered staff did not ensure that the resident, who had a significant weight loss over a period of six months was not assessed using an interdisciplinary approach. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 with r. 69 where every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months. 4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person in subsection (1) performed their responsibilities before receiving training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

LTC Inspectors identified non-compliance in relation to the policy to promote the prevention of abuse and neglect related to resident #011 during the home's annual 2016 Resident Quality Inspection. Review of the home's education and training files for 2015, and 2016, and interview with the DOC confirmed that 34 out of 38 direct care provider staff in the home had received annual retraining related to the home's policy to promote zero tolerance of abuse. The home's staffing compliment included 12 registered staff and 26 PSW staff; a combined total of 89 percent (%) course completed was identified as not meeting the requirement for all staff to receive the annual training. [s. 76. (2) 3.]

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 with s. 76(2)(3) where every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On an identified date in November 2016, LTC Inspector was interviewing resident #016 in their room, and found an identified medication in a medication cup sitting on the side table. Resident #016 stated that they had brought the identified medication to their room after breakfast and had not taken the identified medication. The registered staff was informed right away. The medication administration record (MAR) was reviewed and indicated that the medication was a scheduled medication to be administered three times a day. There was no order from the physician indicating that resident could administer any medications to themselves. Registered staff #103 confirmed that there was no order for self-administering a medication for this resident. A review of the home's policy titled "Medication Management", last revised February 2016, stated, " Under no circumstances, at any time, are medications to be left at the bedside of a resident unless there is an order for it", and that "prior to self medication the nurse will complete an evaluation for self administration of medication". The DOC confirmed that the resident should have been monitored to ensure that all medication was taken. [s. 131. (5)]

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 with r. 131(5) where the licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they provided training related to continence care and bowel management to all staff who provide direct care to residents.

The home's training records for 2015, and 2016, related to continence care and bowel management were reviewed. It was identified that there were 34/38 or 89% (percent) of direct care providers trained in 2015. The attendance breakdown for training identified: 12/12 registered staff, and 22/26 PSWs completed training on continence care and bowel management in 2015. The DOC confirmed that not all of their direct care providers were trained in 2015.
The home failed to ensure that all direct care staff where provided training in continence care and bowel management. [s. 221. (1) 3.]

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 with r. 221(1)(3) where for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents: 3. Continence care and bowel management, to be implemented voluntarily.

Issued on this 20th day of January, 2017

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

Original report signed by the inspector.

Ontario

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

Ministére 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SAMANTHA DIPIERO (619), DARIA TRZOS (561)
Inspection No. / No de l'inspection :	2016_449619_0032
Log No. / Registre no:	032843-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 9, 2017
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

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare and submit a plan of corrective action that shall:
a. Ensure that all residents, including but not limited to resident #011, are protected from abuse by anyone and are not neglected by the licensee or staff.
b. Provide education and training for all staff in relation to procedures and interventions to assist and support residents who have been allegedly abused whether suspected or witnessed to promote zero tolerance of abuse and neglect of residents.
c. Ensure 100 percent completion of training on the home's policy for the prevention of abuse and neglect for all staff.
d. Ensure staff comply with the home's policy in relation to the prevention of abuse and neglect

Prepare and submit the plan to Samantha.Dipiero@ontario.ca by March 31, 2016.

Grounds / Motifs :

1. Judgement Matrix
- Non-Compliance Severity: Actual harm or risk for actual harm
- Non-Compliance Scope: Isolated
- Compliance History: One or more related non-compliances in the last three years

2. The licensee failed to ensure that a resident was protected from abuse by anyone.

On an identified date in March 2016, resident #011 was displaying an unmanaged, ongoing responsive behaviour. Interview with resident #011

indicated that they complained to PSW #111 about not assisting a co-resident, and was admonished by PSW #111 for doing so. PSWs #109, #110, and #112, other residents, family, visitors, and volunteers witnessed PSW #111verbally abuse the resident. Interview with resident #011 indicated that PSW #111 physically abused the resident. Resident #011 stated that the physical abuse caused them to experience pain and experience fear and anxiety.

Interviews with PSWs #109, #110 and #112, as well as dietary aide #107 indicated that these staff were present in the dining room when PSW #111 verbally and physically abused resident #011. All staff present stated that they did not witness the physical abuse but witnessed the verbal abuse, and that none of these staff members intervened to stop the verbal abuse as it occurred. PSW #110 stated "I just put my head down and focused on my resident". PSW #111 was removed from the area by the home's Administrator after continuing to argue with the family member of another resident.

A review of PSW #109, #110, #111, #112, and dietary aide #107's training history indicated that the staff members had completed the home's anti- abuse training for the 2016 calendar year. A review of PSW #111's disciplinary history in the home indicated that PSW #111 was previously disciplined and was no longer employed by the home.

The home's policy titled, "Abuse and Neglect Prevention Program", last revised January 2016, stated that, "Residents of the facility have the right to be free from any form of abuse, neglect, or violence that could threaten their physical or mental well-being". Interview with DOC confirmed that the resident was not protected from abuse by PSW #111 in that, this staff member physically and verbally abused resident #011, and by staff members #107, #109, #110, and #112 for not intervening to protect the resident from abuse. [s. 19. (1)] (619)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

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 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Samantha Dipiero

Service Area Office /
Bureau régional de services : Hamilton Service Area Office