Ontario

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 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
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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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
Sep 24, 2019	2019_723606_0020	012207-19, 014418-19	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)

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): September 9, 10, 11, and 12, 2019. Long Term Care Homes (LTCH) Inspector Lucia Kwok #752 took part in this inspection.

The following intakes were inspected:
Log #012207-19 and Log #014418-19 regarding a resident fall resulting in a serious injury.

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

During the course of the inspection, the Inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records such as progress notes, assessments, physician orders, written care plans, home's meeting minutes, and relevant policies and procedures.

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

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

- **1 WN(s)**
- **1 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	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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or Regulation required the licensee to have, institute or otherwise put in place any policy or procedure, the policy and procedure were complied with.

In accordance with s. 48(1) and in reference to s 49, Section 49(1) of O. Reg. 79/10 required the falls prevention management program to provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, the licensee failed to comply with its policy entitled, "Falls Prevention and Management Program which directed the registered staff to complete a falls assessment after a resident had fallen and to include an assessment of an identified resident attire well as environmental and equipment safety concerns. The policy required an immediate intervention be put in place by the nurse during the same shift that the fall occurred. The family/Substitute Decision Maker (SDM) was to be notified of the fall to discuss new interventions and to document the conversation in Point Click Care (PCC). Staff were required to work with residents and their families to eliminate all possible hazards in the resident's room and bathroom. The resident was supposed to be evaluated and monitored for an identified number of hours after the fall. A Head Injury Routine (HIR) was initiated if a fall was not witnessed or there was a reported head injury. The HIR schedule of assessments stated that the resident was to be assessed at specific time intervals unless there were changes.

1. A Critical Incident System reported resident #001 fell and sustained a serious injury.

Resident #001's progress notes stated that the resident was found on the floor. The progress notes identified that one of the contributing factors that may have caused the resident to fall was due to an identified attire of the resident.

Identified home reports, and risk assessments of resident #001 stated that an identified attire of the resident was a contributing factor in previous falls. Resident #001's plan of care stated that the resident has had a number of falls due to the same identified attire of the resident. There were no interventions found in the plan of care to manage this risk.

Resident #001's clinical records including progress notes, assessments, and plan of care did not show evidence that the resident's family/SDM was informed that an identified attire of the resident were a contributing factor and a falls' risk for the resident.

Registered Nurse (RN) #104 acknowledged that an identified attire of the resident was a contributing factor in the resident's fall on an identified date.

Personal Support Worker (PSW) #100 and RN #105 acknowledged that an identified attire of the resident #001 was considered a falls risk to the resident. RN #105 stated that when the home had identified a resident to have an identified attire that was unsafe, the family/SDM would be notified and would be asked to provide an identified attire that were considered safe. They stated that resident #001's family/SDM was not informed that that resident #001's identified attire was considered unsafe and assessed as a falls risk for the resident until after they fell on an identified date and sustained a serious injury.

The licensee has failed to communicate with resident #001's family as required in their Falls Prevention and Management Program.

2. A) CIS reported resident #001 fell and sustained a serious injury. Resident #001 clinical records were reviewed and revealed the resident had fallen several times. On identified dates, staff found resident #001 the floor. The HIR was reviewed for these falls and showed incomplete assessements for a number identified times.

B) A CIS reported resident #002 fell and sustained a serious injury. Resident #002's clinical records were reviewed and revealed the resident had a history of falls. Resident #002 had an unwitnessed fall on an identified date and showed no evidence that a HIR was initiated. This was confirmed by the Director of Care (DOC).

C) Resident #003 had a fall on an identified date and was found on the floor. A HIR was

initiated on an identified date and showed the re-assessments required for identified dates and times were incomplete.

Registered Practical Nurse (RPN) #102, and RN #105 stated that when a resident had a head injury or an unwitnessed fall, a HIR was to be completed.

The DOC stated that the home's expectation was for staff to complete a HIR according to the home's policy.

The licensee failed to follow the home's HIR as required in their Falls Prevention and Management Program for residents #001, #002, and #003. (606) (752). [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 the home's Falls Prevention and Management Program that directs registered staff to notify the Family/SDM of the fall and discuss any new interventions such as ensuring the resident wears safe footwear is complied with, to be implemented voluntarily.

Issued on this 26th day of September, 2019

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

Ministère de la Santé et des Soins de longue durée

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

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)
Inspection No. / No de l'inspection :	2019_723606_0020
Log No. / No de registre :	012207-19, 014418-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 24, 2019
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 :	Helen Eby

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

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

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The Licensee must be compliant with s. 8(1)(b) of O. Reg. 79/10.

Specifically, the licensee must comply with the home's Falls Prevention and Management Program and ensure that when resident #001, #002, and #003, and any other resident has fallen, the resident is evaluated and monitored for a number of hours. The registered staff must initiate a Head Injury Routine (HIR) if the fall is witnessed or there is a reported head injury. The resident must be assessed according to the home's HIR schedule of assessments at identified time intervals unless there were changes.

Grounds / Motifs :

1. The licensee failed to ensure that where the Act or Regulation required the licensee to have, institute or otherwise put in place any policy or procedure, the policy and procedure were complied with.

In accordance with O. Reg. 79/10, s. 30, the licensee was required to provide a written description of each of the interdisciplinary programs, including falls management. Section 49(1) of O. Reg. 79/10 required the falls prevention management program to provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, the licensee failed to comply with its policy entitled, "Falls Prevention and Management Program", which stated that after a resident fall, The resident was supposed to be evaluated and monitored for an identified number of hours after the fall. A Head Injury Routine (HIR) was initiated if a fall was not witnessed or there was a reported head injury. The HIR schedule of assessments stated that the resident was to be assessed at specific time intervals unless there were changes.

2. A) CIS reported resident #001 fell and sustained a serious injury. Resident #001 clinical records were reviewed and revealed the resident had fallen several times. On identified dates, staff found resident #001 the floor. The HIR was reviewed for these falls and showed incomplete assessements for a number identified times.

B) A CIS reported resident #002 fell and sustained a serious injury. Resident #002's clinical records were reviewed and revealed the resident had a history of falls. Resident #002 had an unwitnessed fall on an identified date and showed no evidence that a HIR was initiated. This was confirmed by the Director of Care (DOC).

C) Resident #003 had a fall on an identified date and was found on the floor. A HIR was initiated on an identified date and showed the re-assessments required for identified dates and times were incomplete.

Registered Practical Nurse (RPN) #102, and RN #105 stated that when a resident had a head injury or an unwitnessed fall, a HIR was to be completed.

The DOC stated that the home's expectation was for staff to complete a HIR according to the home's policy.

The licensee failed to follow the home's HIR as required in their Falls Prevention and Management Program for residents #001, #002, and #003.

The severity of non compliance was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 3 widespread as it related to three out of three residents reviewed. The home had a level 3 history of a previous NC to the same

subsection with a Voluntary Plan of Correction (VPC) during a Complaint Inspection #2018_601532_0022 issued on November 30, 2018. (752) (606)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 15, 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 24th day of September, 2019

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