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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date September 20, 2022
Inspection Number 2022_1303_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Bennett Village

Long-Term Care Home and City
Bennett Centre Long Term Care, Georgetown

Lead Inspector
Romela Villaspir (653)

Additional Inspector(s)
Parimah Oormazdi (741672)

Inspector Digital Signature
Romela Villaspir
2022.09.19
16:19:18 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following dates: September 6-8, 2022.

The following intake was inspected:
Log #007010-22 was related to falls prevention and management.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)

INSPECTION RESULTS

WRITTEN NOTIFICATION REQUIRED PROGRAMS

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 48 (1) 1
The licensee has failed to monitor a resident for 72 hours after a fall, as required by the falls management program.

Rationale and Summary:

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In accordance with O. Reg 79/10 s. 8 (1) (b), the licensee is required to ensure that the home's falls prevention and management policy to reduce the incidence of falls and the risk of injury is complied with.

The registered staff did not comply with the home's Falls Management Program policy, which required them to evaluate and monitor residents for 72 hours after a fall, including vital signs: temperature, pulse, respiration, blood pressure, oximetry every shift for 72 hours, and document in Point Click Care (PCC).

A resident had a fall, and the registered staff did not assess the resident's complete vital signs the following day, on all three shifts.

Two days after the fall, there was a change in the resident's condition. The Nurse Practitioner (NP) was called to assess the resident, and the NP ordered to send the resident to hospital for further assessment.

By not checking the vital signs in the required intervals after a fall, the staff may not have been able to identify a change in the resident's health condition in a timely manner.

Sources: Resident's progress notes, Falls Management Program policy #6.1 revised in August 2020; Interviews with the Resident Care Coordinator (RCC), a Registered Nurse (RN), and other staff.

[741672]