Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8

Original Public Report

Report Issue Date: April 5, 2023	
Inspection Number: 2023_1303_0002	
Inspection Type: Proactive Compliance Inspection (PCI)	
Licensee: Bennett Village	
Long Term Care Home and City: Bennett Centre Long Term Care, Georgetown	
Lead Inspector Katherine Adamski (#753)	**Inspector Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2023.04.05 15:04:20 -04'00'
Additional Inspector(s) Alicia Campbell (#741126)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 22-24, 27-31, 2023

The following intake(s) were inspected:

- Intake: #00022855 - Bennet Centre LTC PCI

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10)(b)

The licensee failed to ensure that a resident was reassessed and plan of care was reviewed and revised when their care needs changed, and the care set out in their plan was no longer necessary.

A residents' plan of care related to nutrition included a specific intervention for assistive devices.

The residents' plan of care was not reflective of their current care needs, and the specific intervention related to assistive devices was no longer necessary.

The resident required a re-assessment by the Dietitian and a referral was completed.

Sources: Observations, the residents' plan of care including care plan, kardex, assessments and progress notes, interviews with the Food Service Manager and other staff.

Date Remedy Implemented: March 27, 2023

[#753]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3)(c)

The licensee failed to ensure the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

The Resident Care Coordinator (RCC) confirmed that the home's policy to promote zero tolerance of abuse and neglect was not posted in the home and ensured it was posted by the end of the day.

Sources: Observations, interview with the RCC.

Date Remedy Implemented: March 27, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3)(r)

The licensee failed to ensure that an explanation of the protections afforded under section 30 (whistle blowing protection) was posted in the home.

The RCC confirmed that an explanation of the protections afforded under section 30 was not posted in the home and ensured it was posted by the end of the day.

Sources: Observations, interview with the RCC.

Date Remedy Implemented: March 27, 2023

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 12 (1) 3.

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

On March 22, 2023, two observations showed that the door to room #2131 was open. The door led to a non-residential area of the home.

Registered Nurse (RN) #105 acknowledged that this door must be closed for safety reasons. Subsequent observations of the door to room #2131 showed that it was closed and locked.

Sources: Observations, interviews with RN #105 and other staff.

Date Remedy Implemented: March 23, 2023

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 20 (a)

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that could be accessed and used by a resident.

Personal Support Worker (PSW) #110 acknowledged that a resident's call bell was not functioning

properly. Later that day, the resident's call bell was activating appropriately.

Sources: Observations, interviews with PSW #110 and other staff.

Date Remedy Implemented: March 22, 2023

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 265 (1) 10.

The licensee failed to ensure that the home's visitor policy was posted in the home.

The RCC confirmed that the home's visitor policy was not posted in the home and ensured it was posted by the end of the day.

Sources: Observations, interview with the RCC.

Date Remedy Implemented: March 27, 2023

[#741146]

WRITTEN NOTIFICATION: Behaviours and Altercations

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents who were at risk of harm or who were harmed as a result of a resident's behaviors, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents #002 and #011.

Rationale and Summary

Residents #002 and #011 had a history of altercations and harmful interactions.

Resident #011 often exhibited verbal behaviours towards resident #002.

On two occasions, resident #002 exhibited physical behaviours towards resident #011.

Neither resident #002 nor #011's care plans contained interventions to minimize the risk of altercations between them. The Director of Care (DOC) acknowledged that no interventions had been documented or implemented to minimize the risk of altercations between the two residents.

With no procedures or interventions implemented to minimize the risk of altercations between residents #002 and #011, both residents continued to be at risk of harm.

Sources: Interviews with resident #002, the DOC and other staff, resident #002 and #011's care plans and progress notes.

WRITTEN NOTIFICATION: Housekeeping

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)

The licensee has failed to ensure that PSW #118 implemented the procedure developed for cleaning and disinfection of resident care equipment.

Rationale and Summary

PSW #118 was observed exiting a resident room with a lift and placing it in the hallway. When asked if the lift was disinfected after this use, PSW #118 indicated that it was not.

The Infection Prevention and Control (IPAC) Lead stated that shared equipment should be disinfected after every use with the disinfectant wipes in the home.

Sources: Observations, interviews with the IPAC Lead and other staff, Routine Practices Policy (most recently reviewed 01/23).

[#741126]

WRITTEN NOTIFICATION: Resident and Family Experience Survey

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)

The licensee failed to seek the advice of the Residents' Council and the Family Council in carrying out the survey and in acting on its' results.

Rationale and Summary

The Resident and Family Council Meeting Minutes showed that the home had not sought the advice of the councils in developing and carrying out the satisfaction survey, and in acting on its' results.

The Family Council Chair and Liaison to the councils acknowledged that the home had not sought the advice of the Resident and Family Council in developing and carrying out the satisfaction survey, and in acting on its' results.

There was potential risk that residents' and family council member concerns related to care or the operation of the home were not considered or addressed when they were not asked for their advice with the satisfaction surveys.

Sources: Interviews with Resident Council President, Family Council Chair and Liaison for the councils, Resident and Family Council Meeting Minutes from October 2022 to March 2023.

WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2)

The home failed to ensure that the continuous quality improvement (CQI) committee was composed of at least the following persons: 3. The home's Medical Director. 4. Every designated lead of the home. 5. The home's registered dietitian. 6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider. 7. At least one employee of the licensee who is a member of the regular nursing staff of the home. 8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52. 9. One member of the home's Residents' Council. 10. One member of the home's Family Council, if any.

Rationale and Summary

The home's CQI committee consisted of the management team including the Executive Director (ED) and their Administrative Assistant, the DOC, RCC and the BSO Lead.

When all the required members were not included in the committee, representation from all areas of the home to provide suggestions for improvement opportunities could not be considered.

Sources: Terms of References for Committees, Quality of Care Policy and Procedures, interviews with the ED and other staff.

WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (5)

The licensee failed to prepare an interim report for the 2022-2023 fiscal year, within three months of the Fixing Long-Term Act, 2021 coming into force.

Rationale and Summary

The Fixing Long-Term Act, 2021, and O. Reg. 246/22 came into effect on April 11, 2022.

As per O. Reg. 246/22 s. 168 (5), it states that every licensee of the long-term care home (LTCH) shall, within three months of coming into force of this section, prepare an interim report for the 2022-2023 fiscal year.

The ED acknowledged that the home had not prepared the interim CQI report for the 2022-2023 fiscal year.

Sources: The home's 2023/2024 CQI Plan, interviews with the ED and other staff.

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