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
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 24, 2023	
Inspection Number: 2023-1303-0003	
Inspection Type: Critical Incident System	
Licensee: Bennett Village	
Long Term Care Home and City: Bennett Centre Long Term Care, Georgetown	
Lead Inspector Romela Villaspir (653)	**Inspector Digital Signature** Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.05.25 09:30:38 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 16-18, 2023, and off-site on May 19, 2023.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake #00006392 was related to abuse.
- Intake #00022298 was related to falls prevention and management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident's plan of care sets out clear directions to staff and

others who provided direct care to the resident.

Rationale and Summary

A resident was at risk for falls, and they had multiple falls in a span of three months.

The Physiotherapist (PT) recommended interventions to prevent future falls for this resident. These interventions were also discussed during two falls committee meetings, and documented in the minutes.

The Falls Lead indicated that the PT's recommendation for the resident's falls interventions should be included in the care plan, and the Personal Support Workers (PSWs) would follow the care plan. The Falls Lead checked the resident's care plan and acknowledged that it did not include the falls interventions recommended by the PT.

By not setting out clear directions on the resident's plan of care, the falls interventions recommended by the PT may not have been consistently done by the staff.

Sources: Resident's clinical health records; Interviews with the PT, Falls Lead, and other staff. [653]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in a resident's plan of care was documented.

Rationale and Summary

A resident had a fall on a particular shift.

The Point of Care (POC) records on that shift showed no documentation of care provided to the resident.

The Director of Care (DOC) indicated that the home's expectation was for the PSWs to document all care that was provided to the residents, on POC.

Sources: Resident's clinical health records; Interview with the DOC. [653]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from abuse.

Rationale and Summary

The home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care (MLTC) related to abuse.

A staff member's abusive actions and behaviours towards a resident, caused the resident pain and made them restless.

Sources: Resident's clinical health records, CI report, the home's video surveillance and investigation notes, Staff member's termination letter, Police Report; Interviews with the Resident Care Coordinator (RCC), Executive Director (ED), and other staff. [653]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with by a RN.

Rationale and Summary

The home's written policy to promote zero tolerance of abuse and neglect of residents, requires the staff to immediately report alleged abuse to their immediate Manager, and ensure the resident's safety immediately and on an ongoing basis which includes but is not limited to emotional and physical assessments. The Attending Physician and POA (Power of Attorney)/ Substitute Decision-Maker (SDM) shall be notified immediately, and an investigation shall be commenced immediately. While the

investigation is being conducted, the suspected/ accused staff member shall be relieved of their duties with pay and escorted from the building while the investigation is being conducted.

A RN did not take the necessary actions as required by the home's policy, in the staff to resident abuse incident referenced in NC #003.

By not following the home's policy, the risk to the resident was not mitigated as the staff member remained in the facility until they finished their entire shift, and any potential injuries to the resident may not have been identified due to the lack of assessments.

Sources: Resident's clinical health records, CI report, the home's investigation notes, Non-Abuse Program policy revised in April 2022; Interviews with the RN, RCC, and the ED. [653]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that the masking requirements as set out in the Minister's Directive, were followed by two staff members.

Rationale and Summary

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes effective August 30, 2022, the licensee was required to ensure that the masking requirements as set out in the COVID-19 guidance document for long-term care homes in Ontario, were followed.

The guidance document updated on August 30, 2022, required homes to ensure that all staff wear a medical mask for the entire duration of their shift.

For staff: homes must ensure that all staff comply with masking requirements at all times, even when they are not delivering direct patient care, including in administrative areas. Masks must not be removed when staff are interacting with residents or in designated resident areas.

In the home's video surveillance footages of the staff to resident abuse incident referenced in NC #003, there were times when two staff members were not wearing surgical masks when they interacted with a resident. In those instances, the staff members were not physically distanced from the resident as well. The Infection Control Lead indicated that the staff were required to wear a surgical mask at that time.

By not adhering to the universal masking requirements, there was potential risk for resident and staff exposure to infectious microorganisms.

Sources: The home's video surveillance; Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario; Interviews with the Infection Control Lead, and the ED. [653]