Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
Oct 17 and 19, 2011	2011_026147_0033	Critical Incident

Licensee/Titulaire
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(s)

Laleh Newell - 147

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector spoke with: Administrator, Director of Care (DOC), staff and Residents.

During the course of the inspection, the inspector: Reviewed clinical charts and progress notes, reviewed Policy and Procedure related to abuse and neglect, Falls Prevention and Complaint and Concerns Reports, internal investigation and Internal incident report reviewed and the personnel files of the staff who was involved in the incident reviewed.

H-001395-11 and H-001882-11

********Amended Public Report with Original WN #5 - LTCHA, 2007 S.O. 2007, c.8, s 24(2) replaced with O.Reg 79/10, s. 24(1)2**

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN
6 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

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 subsections:

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).

Findings:

1. The home failed to comply with the Falls Prevention policy. An identified resident had a fall in 2011 and sustained an injury. According to the home's policy and procedure related to Falls Respond and Documentation, registered staff are to respond quickly to the fall and notify the physician via Fax Alert regarding the resident's fall and respond to the direction. The registered staff did not send a Fax Alert to the physician after the resident fell in 2011.
2. According to the home's policy and procedure related to Falls Prevention and Management Program the resident's plan of care is reviewed and recommendation for safety that are made by the team are included in the resident's plan of care. An identified resident had a fall in 2011, the Interdisciplinary Falls Committee met after the resident's fall made recommendations for safety, however the plan of care did not include the safety recommendation for this resident at the time of the inspection.

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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 to ensure the licensee 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 is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:
s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings:

1. The home failed to ensure that the Director was informed no later that one business day, following an incident in the home which a person with an injury was taken to hospital. An identified resident fell in 2011 and sustained an injury and sent to hospital for further assessment, however the home did not notify the Director until four business days after the incident.

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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 to ensure that the Director is informed no later that one business day of an injury in respect of which a person is taken to hospital, to be implemented voluntarily.

WN #3: 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 subsections:
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:

1. The home did not ensure an identified resident was protected from abuse by the staff. In 2011 it was witnessed by another staff in the home that an identified resident was abused by a staff member while providing care to the resident.

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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 to ensure the home shall protect residents from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:
s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings:

1. The home failed to ensure every alleged, suspected or witnessed incident of abuse of a resident in the home is immediately investigated. An incident of abuse was witnessed by a staff member of the home by another staff member. This incident was reported to the Acting Director of Care (ADOC) in writing, however the home failed to immediately investigate this witnessed incident of abuse of the resident until several days later.

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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 to ensure every alleged, suspected or witnessed incident of abuse of a resident by anyone is reported to the licensee is immediately investigated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:
24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1.Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2.Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3.Unlawful conduct that resulted in harm or a risk of harm to a resident.

4.Misuse or misappropriation of a resident's money.
5.Misuse or misappropriation of funding provided to a licensee under this Act. 2007, c. 8, s. 24 (1).

Findings:

1. The home failed to ensure an abuse of a resident by a staff that resulted in harm or risk of harm was immediately reported to the Director. An incident of abuse was witnessed by a staff member of the home by a staff member towards an identified resident. This incident was reported to the Acting Director of Care (ADOC) in writing, however the home did not ensure the report was submitted immediately to the Director after becoming aware of the witnessed incident.

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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 a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: 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 subsections:
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:

1. In 2011 it was witnessed by another staff in the home that an identified resident was abused by a staff member while providing care to the resident. The home failed to comply with their Abuse and Neglect Prevention Program by allowing the staff to continue to work with the resident after the incident had occurred and before the home's internal investigation was completed.

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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 to ensure every licensee shall have in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy in complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit Movement

Specifically failed to comply with the following subsections:
s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,

iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings:

1. The home failed to ensure the use of the PASD had been approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulation. An identified resident had a fall 2011 and sustained an injury. The resident's plan of care revised following the fall included strategies and interventions related to a seat belt for safety while in wheelchair. According to interview with the Director of Care and the registered staff and recommendation from the Interdiciplinary Falls Committee Team, the seat belt is a Personal Assistance Services Device (PASD) as the resident is capable of undoing the seat belt and is used to assist with routine activity of living. The home failed to obtain approval from a physician or a registered nurse for the use of the PASD for the resident. Furthermore, the home also failed to gain consent from the resident's substitute decision-maker for the use of the PASD for the resident.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Feb 17/2012
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).