Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 28, 2013	2013_189120_0073	H-000513-13	Complaint

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 16, 2013

During the course of the inspection, the inspector(s) spoke with administrator, assistant administrator, director of care, infection control designate, ward clerk, registered staff, personal support workers, housekeeping staff and residents.

During the course of the inspection, the inspector(s) toured the home including random resident rooms, common areas and family laundry room, tested the resident-staff communication and response system, reviewed the home's laundry and infection control policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The resident-staff communication and response system does not clearly indicate when activated where the signal is coming from.

The home's system is designed so that staff must wear pagers in order to be alerted to the location of an activated station, especially when they are not in corridors or near the nurse's station. The pagers provide both an audio and a visual signal and work in conjunction with dome lights above resident room doors and a designated desk phone at the nurse's station. During the inspection, none of the health care staff who were interviewed were carrying their pagers. Staff reported that they have not carried their pagers since early May 2013. Staff reported that they have had to rely on a visual alert, which is the light dome next to each door and that if they are close enough to the nurse's station, they can hear a sound emitting from a desk phone alerting them of an activated station. However, staff who are in a resident room, in the dining room assisting residents or in the tub room, they do not know when and if residents have activated their station.

Management staff contacted their resident-staff communication and response system contractor immediately upon notice of the failure in May 2013 for repair. New components were installed on August 19, 2013 but were not successful. Additional changes have been scheduled and the system is expected to be functional by October 31, 2013. [s. 17(1)(f)]

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 resident-staff communication and response system can clearly indicate when activated where the signal is coming from, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

Procedures for laundry services have been developed but have not been implemented to ensure that resident's personal clothing be labeled and returned to the resident within 48 hours.

During the inspection, over 10 bundles or bags of clothing were observed in the home's family laundry room waiting to be labeled. Three bundles or bags of clothing were dated September 29 and 30th, 2013. The rest were dated between October 1 and 12th, 2013. The home has a label machine and label press and two designated employees who share the responsibility of labeling as one of their tasks. The home's policy dated November 2009 and titled "Personal Clothing - Admission" requires that the Ward Clerk label new clothing items brought in by family as soon as possible. Another policy titled "Personal Clothing - Handling of Lost Clothing and Unclaimed Clothing" states that when clothing (without a label) is identified belonging to someone, that the nurse is to label the article. However no time frame was provided to complete the task. [s. 89(1)(a)(ii)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

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):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee did not ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

2. An environmental hazard that affects the provision of care or the safety, security or well being of one or more residents for a period greater than six hours, including,

iii. a loss of essential services

The management of the home first identified that the resident-staff communication and response system (an essential service) was not functioning properly (pagers were not receiving signals) on May 1, 2013. During the inspection on October 16, 2013, the system was still not fully functional. No alternative provisions were made to ensure that staff could respond in a timely manner when a station was activated. [s. 107(3) 2.iii]

Issued on this 28th day of October, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

B. Sosnik