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**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 25, 2014 | 2014_301561_0010 | H-000374-13 | 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**

DARIA TRZOS (561)

## 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): May 21, 22 and 23, 2014**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), RAI Coordinator, Registered Staff, Personal Support Workers (PSWs), Physiotherapist and family member.**

**During the course of the inspection, the inspector(s) toured the home, observed provision of care on all home areas, reviewed health care records, written communication records between family and management staff at the home and reviewed relevant policies and procedures.**

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

**Falls Prevention**
**Infection Prevention and Control**
**Skin and Wound Care**

**Findings of Non-Compliance were found during this inspection.**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 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.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee did not ensure that the resident, and the resident's substitute decision-maker was given opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #001 was tested and found positive for an infection upon return from the hospital. The home failed to notify the substitute decision maker about resident's condition. Family visited resident on numerous occasions without being aware of risks and did not find out about resident's infection until seven days later. Resident's records were reviewed and there was no documentation stating that family was aware of resident's condition. DOC confirmed that this information was missed and family was not informed. [s. 6. (5)]

2. The licensee did not ensure that the plan of care was reviewed and revised when the resident's care needs changed.

A. Resident #001 acquired an infection during stay in the hospital. Upon return from the hospital resident was routinely tested and results revealed that resident was positive for an infection. Resident's plan of care did not include any information related to resident's condition and did not include any interventions that were in place for resident or staff. RAI coordinator and DOC both confirmed that resident's plan of care should have been revised with this information.

Resident #002 and #003 were both on isolation precautions in April 2014. Residents' plans of care were reviewed and did not include this information. RAI coordinator reported that plans of care must be revised when care needs change and confirmed that staff did not update the plans of care for these residents.

B. Resident #001 had a fall in March 2013 and was sent to the hospital for assessment. When the resident returned from the hospital an assessment was done by a Physiotherapist. Physiotherapist recommended the use of a wheelchair for transportation and for staff to monitor resident closely for compliance. The home provided a loaner wheelchair until resident could be assessed by an Occupational Therapist. Resident #001 had a second fall which was unwitnessed and resulted in an injury. Resident was sent to the hospital for treatment. The interview with RAI coordinator revealed that resident was not able to propel on her own using the wheelchair and was alone in the room before the fall. Staff did not follow Physiotherapist's recommendation to monitor resident closely. Resident's plan of care was reviewed and showed that the Physiotherapist's recommendation for the use of a wheelchair was not included in resident's plan of care. Physiotherapist confirmed that resident's plan of care was not revised with this information at the time. [s. 6. (10) (b)]

***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 ensure that the resident, and the resident's substitute decision-maker is given opportunity to participate fully in the development and implementation of the resident's plan of care and that the plan of care is reviewed and revised when resident's care needs change., to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

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**Findings/Faits saillants :**

1. The licensee did not ensure that the staff participated in the implementation of the infection prevention and control program

Resident was tested positive for an infection upon return from hospital in March of 2013. Registered staff failed to communicate the results to all other staff that provided direct care to the resident. The signage with additional precautions was not posted at resident's door and Personal Protective Equipment (PPE) was not available at the entrance to resident's room. The interview with a Personal Support Worker (PSW) indicated that staff was not aware of resident's condition at the time. Resident's health care records did not indicate that resident had an infection. Director of Care (DOC) confirmed that the results of an infection for resident #001 somehow were not communicated to staff and the infection prevention and control procedure was not followed. [s. 229. (4)]

***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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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**Issued on this 27th day of June, 2014**

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