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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 21, 2017	2017_695156_0002	022798-17	Resident Quality Inspection

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
2121 Argentia Road Suite 301 MISSISSAUGA ON L5N 2X4

Long-Term Care Home/Foyer de soins de longue durée

Hardy Terrace
612 Mount Pleasant Road, R.R. #2 BRANTFORD ON N3T 5L5

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

CAROL POLCZ (156), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 26, 27, 28, 29, October 3, 4, 5, 2017.

During this inspection the inspections listed below were conducted concurrently:

Critical Incident Reports
029496-16 related to falls prevention
006825-17 related to falls prevention

Complaints
010340-17 related to medication administration, staffing, falls prevention, plan of care
017768-17 related to continence care, infection prevention
010026-17 related to staffing
010174-17 related to continence care and maintenance

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Office Manager, Food Service Supervisor (FSS), Resident Assessment Instrument Co-ordinator (RAI), registered nurses (RNs), registered practical nurses (RPNs), consultant pharmacists, Personal Support Workers (PSWs), food service workers, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, observed medication passes, meal service, snack passes, reviewed clinical records, policies and procedures, the home's complaints process, investigative notes and conducted interviews.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **9 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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. 91. Resident charges

Findings/Faits saillants :

1. The licensee failed to ensure that they did not cause or permit anyone to make a charge or accept such a payment on the licensee's behalf.
Ontario Regulation 79/10 section 245 paragraph 1 identified the following:
"The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,

i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act".
The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies. The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long-Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".
As per regulation 51(2)(h) residents are to be provided with a range of continence care products that are based on their individual assessed needs, properly fit the resident, promote resident comfort, ease of use, dignity and good skin integrity, promote continued independence whenever possible and are appropriate for the time of day, and for the individual resident's type of incontinence. It was determined through assessment that the most appropriate product to fullfil the requirement above, for resident #007 was a specified product. The licensee permitted the resident's representative to make a charge or accept a payment on the licensee’s behalf for continence care products, which they received funding from the local health integration network under their service accountability agreement.

A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee’s behalf.

The plan of care for resident #007 indicated that the resident was incontinent and required a specified product on all three shifts. Staff were to toilet the resident regularly each shift as specified. Observation of the closet card for this resident on October 3,

2017, indicated that staff were to use a specified product for two shifts which were provided by the family. Interview with PSW staff #105 and #106 as well as the ADOC confirmed that the resident used a specified product supplied by the family. The ADOC confirmed that the resident was not offered a range of continence care products including the specified product supplied by the home; however, since the time of inspection, the home has been providing the resident with the specified product. [s. 91. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy LTC-RCM-I-10.00 Hydration & Nutritional Monitoring effective January 2015 indicated that PSW's would utilize the hydration and nutrition sections on the flow sheets or point of care record for ongoing tracking of food and fluid consumption of assigned residents throughout each shift. Staff were to identify all food consumed at designated times as a percentage of the whole amount of the food provided at that time and identify beverages as number of servings. At the end of the shift, staff were to enter the total number of servings a resident had consumed in the appropriate space on the resident's flow sheet. Totals would be automatically calculated in the point of care system.
Interview with the Administrator confirmed that the expectation was that documentation was to be completed accurately.
A meal was observed in October, 2017.
A) Resident #031 was observed by the LTC Inspector to have consumed approximately three quarters of the meal; however, was documented by staff as having consumed 100% of the meal.
B) Resident #002 was observed by the LTC Inspector to have consumed approximately half of the meal; however, was documented by staff as having consumed 100% of the

meal.
C) Resident #030 was observed by the LTC Inspector to have consumed approximately one quarter to half of the meal; however, was documented by staff as declining the meal.

The PM snack pass was observed on October 4, 2017 in the secure area. It was noted that the residents were provided with 125 ml glasses for juices/water and a nutritional supplement was in pre-labelled 175 ml glasses. The pass was observed for all residents listed below and confirmed to be complete (no other snack or beverage was offered) by staff #112.
A) Resident #023 was observed consuming a 125 ml glass of juice by the LTC Inspector; however, it was inaccurately recorded by staff as 350 ml.
B) Resident #015 was observed consuming a 125 ml glass of juice by the LTC Inspector; however, it was inaccurately recorded by staff as 175 ml.
C) Resident #021 was observed consuming one quarter of a 125 ml glass of juice (31.25 ml) by the LTC Inspector; however, it was inaccurately recorded by staff as 87.5 ml.
D) Resident #022 was observed consuming a 125 ml glass of juice by the LTC Inspector; however, it was inaccurately recorded by staff as 175 ml.
E) Resident #004 was observed consuming three quarters of a 125 ml glass of juice (93.75 ml) by the LTC Inspector; however, it was inaccurately recorded by staff as 175 ml.
F) Resident #024 was observed consuming two 125 ml glasses of juice (250 ml) by the LTC Inspector; however, it was inaccurately recorded by staff as 350 ml.
G) Resident #013 was observed consuming half of a 125 ml glass of water (62.5 ml) by the LTC Inspector; however, it was inaccurately recorded by staff as 175 ml.
The home's policy LTC-RCM-I-10.00 Hydration & Nutritional Monitoring was not found to be complied with. [s. 8. (1) (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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint.
A) Email correspondence expressing care concerns related to resident #007 on an identified date in January, 2017, was sent by the SDM of resident #007 to the DOC. Review of the home's complaint and concern log for 2017 did not include any investigation into the resident's concerns. Interview with the Administrator confirmed that the complainant had concerns which were not investigated and resolved.
B) Email correspondence expressing care concerns related to resident #007 on an identified date in April, 2017, was sent by the SDM of resident #007 to the ADOC. Review of the home's complaint and concern log for 2017 did not include any investigation into the resident's concerns. Interview with the Administrator confirmed that the complainant had concerns which were not investigated and resolved.
C) Email correspondence expressing care concerns related to resident #007 on an identified date in May, 2017, was sent by the SDM of resident #007 to the ADOC. Review of the home's complaint and concern log for 2017 did not include any investigation into the resident's concerns. Interview with the Administrator confirmed that the complainant

had concerns which were not investigated and resolved.
The complaints were not found to be investigated and resolved where possible, and a response that complied with paragraph 3 was not provided within 10 business days of the receipt of the complaint. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

A) Email correspondence expressing care concerns related to resident #007 on an identified date in November, 2016 was sent by the SDM of resident #007 to the DOC. An investigation and response was provided during the care conference to the complainant but was not included in the 2017 complaints log, as required.
B) Email correspondence expressing care concerns related to resident #007 on an identified date in November, 2016 was sent by the SDM of resident #007 to the ADOC. An investigation and response was provided to the complainant in person but was not included in the 2017 complaints log, as required.
C) Email correspondence expressing care concerns related to resident #007 on an identified date in November, 2016 was sent by the SDM of resident #007 to the DOC. An investigation and response was provided to the complainant but was not included in the 2017 complaints log, as required.
D) Email correspondence expressing care concerns related to resident #007 on an identified date in January, 2017, was sent by the SDM of resident #007 to the DOC. Review of the home's complaint and concern log for 2017 did not include any investigation into the resident's concerns. Interview with the Administrator confirmed that the complainant had concerns which were not investigated and resolved; and was not included in the 2017 complaints log, as required.
E) Email correspondence expressing care concerns related to infection control practices, staffing and maintenance issues on an identified date in February, 2017 was sent by the SDM of resident #007 to the Administrator. An investigation and response was provided to the complainant but was not included in the 2017 complaints log, as required.

F) Email correspondence expressing care concerns related to resident #007 on an identified date in April, 2017, was sent by the SDM of resident #007 to the ADOC. Review of the home's complaint and concern log for 2017 did not include any investigation into the resident's concerns. Interview with the Administrator confirmed that the complainant had concerns which were not investigated and resolved; and was not included in the 2017 complaints log, as required.
G) Email correspondence expressing care concerns related to resident #007 on an identified date in May, 2017, was sent by the SDM of resident #007 to the ADOC. Review of the home's complaint and concern log for 2017 did not include any investigation into the resident's concerns. Interview with the Administrator confirmed that the complainant had concerns which were not investigated and resolved; and was not included in the 2017 complaints log, as required. [s. 101. (2)]

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 a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for
actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the
response; and
(f) any response made in turn by the complainant, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

In September, 2017, resident #005 was observed by the LTC Homes Inspector to have a dressing applied and was noted to be bleeding. RPN #101 cleansed the area and dressed the area. A review of the resident's clinical record did not include an assessment of the area of altered skin integrity nor were they identified on the treatment assessment record. RN #102 confirmed that the area included areas of altered skin integrity that were identified on a date prior to the observation in September, 2017. RN #102 confirmed on September 29, 2017 that the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for skin and wound until the LTC homes inspector identified that one was not completed. [s. 50. (2) (b) (i)]

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 residents who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On October 3, 2017, at approximately 1600 hours, RPN #107 was observed dispensing medications for resident #005, including an injectable narcotic for the resident. When the RPN unlocked the medication cart, they were able to retrieve the narcotic from the controlled substance bin without unlocking the second lock on the bin and the bin remained open for at least two individual medication passes. Interview with RPN #107 confirmed that the bin lid was not closed all the way after the last narcotic was dispensed and therefore the controlled substances were not double-locked while in the medication cart, as required. [s. 129. (1) (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 to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that medications were stored in an area or a medication cart that was secured and locked.

A) On October 3, 2017, at approximately 1600 hours, the medication cart was noted to be sitting outside the dining area unlocked. RPN #107 was giving medications to a resident. The RPN's back was to the medication cart and was unaware that the LTC Inspector was able to open and close medication cart drawers. When RPN #107 returned to the cart, they confirmed that the cart was not locked and secured when unattended.

B) On October 3, 2017, at approximately1600 hours, RPN #107 was preparing resident #007's medications which included a medication crushed in water which then needs to sit and melt; as per the RPN at this time they also added the resident's dose of another medicaiton. This cup of medications were left on top of the medication cart for approximately 10-15 minutes while the RPN was giving other residents their medications and their back was to the cart at times. There were cognitively impaired residents in close proximity to the medication cart. Medications were not kept secured and locked at all times. [s. 130. 1.]

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 medications are stored in an area or a medication cart that is secured and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, and the resident's physician/prescriber of the drug.

The DOC confirmed that if the required notification of a medication incident involving a resident was not documented on the Medication Incident Report (MIR) or in the resident's clinical record then the notification had not occurred.

A) Resident #015 had a designated Substitute Decision Maker (SDM) for both personal care and finances. On an identified date in August, 2017, staff documented on a MIR that the resident did not receive the correct dose of medication. The MIR provided an opportunity for staff to document if they had notified the resident and/or the SDM. Documentation on the MIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident.

B) Resident #016 had a designated Substitute Decision Maker (SDM) for both personal care and finances. On an identified date in July, 2017, staff documented on a MIR that the resident did not receive their medication for three days. The MIR provided an opportunity for staff to document if they had notified the resident, the resident's physician and/or the SDM. Documentation on the MIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical

record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident.

C) Resident #017 had a designated Substitute Decision Maker (SDM) for both personal care and finances. On an identified date in August, 2017, staff documented on a MIR that the resident received a medication twice a day for three days and not once a day as ordered. The MIR provided an opportunity for staff to document if they had notified the resident and/or the SDM. Documentation on the MIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident.

The licensee failed to notify resident #015, #016 and resident #017's SDM that a medication incident had occurred and the licensee failed to also notify resident #016's physician that the medication incident had occurred. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, and the resident's physician/prescriber of the drug, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they were not being supervised by staff.

On an identified date in July, 2017 an activity was held for residents in the courtyard. Following the activity, staff had propped the door open to the courtyard and left resident #007 outside unsupervised. The resident subsequently sustained a fall. There were no injuries from the fall, however, it was confirmed that the door was left open and the resident was not supervised by staff. The licensee failed to ensure that all doors were locked when they were not being supervised by staff which was confirmed in interview with the Administrator on October 5, 2017. [s. 9. (1) 2.]

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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

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 failed to 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 the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #007's SDM had a meeting on an identified date in March, 2017, with the ADOC and at this meeting the SDM clearly indicated that they wanted to be called prior to the resident being given their as needed dose of medication. An interview with the ADOC confirmed that this direction was current and the staff were to call prior to giving the resident the medication. A review of the clinical record confirmed that the resident was given their as needed medication on five occasions: two in September, 2017 and three in March, 2017. There was no documentation in the resident's clinical record confirming that the SDM was called prior to giving the resident their as needed medication as confirmed by the ADOC. [s. 6. (5)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On October 3, 2017, the LTC Homes Inspector was observing the medication pass. It was noted that RPN #107 was pouring a nutritional supplement into Dixie cups without measuring the required dose. Resident #005 had an order to be given a specified amount of the supplement. The RPN poured the supplement into a Dixie cup for resident #005 and went to give the resident the supplement without measuring the required dose. The LTC Homes Inspector asked how they knew that was the required amount and they confirmed that they just know as they do this all the time. The LTC Homes Inspector asked if we could measure how much of the supplement was in the Dixie cup, the RPN complied and it measured only 75% of the required amount and therefore the resident

would not have received the correct dose. A review of the care plan indicated that this resident was assessed at high nutritional risk. The RPN confirmed that it was not the correct dose as they did not measure and that they failed to follow the planned care for the resident. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

The plan of care at the time of the inspection for continence and toileting for resident #002 indicated that the resident was incontinent; and was to wear a specified product on each shift. Interview with registered staff #101 reported that the resident no longer wore the specified product and was currently using a different product. The staff confirmed that the plan of care had not been updated when the resident's care needs had changed. [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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were offered a minimum of a snack in the afternoon and evening.

In October, 2017, the snack pass was observed. Staff #112 was observed assisting residents with beverages, however, not all residents were offered a snack.
A) Resident #021 was noted on the snack list to be offered water to drink first, and snack as per snack rotation. Staff #112 was observed assisting the resident with juice (not water), of which only 1/4 was taken and then the staff moved on to the next resident without offering the resident the available snack.
B) Resident #004 was noted on the snack list to be provided with 175 ml supplement and to be offered the snack as per rotation. Staff #112 was observed assisting the resident with the labelled supplement, which 3/4 was consumed; however, the staff did not offer the resident the available snack.
The staff proceeded to continue with the snack pass for other residents and confirmed that the above noted residents were finished with the pass. The licensee failed to ensure that all residents were offered a snack in the afternoon. [s. 71. (3) (c)]

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 residents are offered a minimum of a snack in the afternoon and evening, to be implemented voluntarily.

Issued on this 22nd day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROL POLCZ (156), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2017_695156_0002
Log No. / No de registre :	022798-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 21, 2017
Licensee / Titulaire de permis :	Diversicare Canada Management Services Co., Inc. 2121 Argentia Road, Suite 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	Hardy Terrace 612 Mount Pleasant Road, R.R. #2, BRANTFORD, ON, N3T-5L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Rooyakkers

To Diversicare Canada Management Services Co., Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Order / Ordre :

The licensee shall ensure that the home does not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf; specifically for continence care supplies or products. 2007, c. 8, s. 91. (4).

The licensee shall reimburse the cost of the continence care products purchased by the family of resident #007 to date and going forward, the home shall provide and purchase the product based on the assessed needs of this resident and all residents.

Grounds / Motifs :

1. This Order is being issued based on the application of the factors of severity (2), scope (1) and compliance history of (2), in keeping with s. 299 (1) of the Regulation. This is in respect to the severity of harm or risk of harm to residents, the scope of the harm or risk of harm to the residents and the home's history of non-compliance.

The licensee failed to ensure that they did not cause or permit anyone to make a charge or accept such a payment on the licensee's behalf.
Ontario Regulation 79/10 section 245 paragraph 1 identified the following:
"The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health

integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act".
The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies. The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long-Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".
As per regulation 51(2)(h) residents are to be provided with a range of continence care products that are based on their individual assessed needs, properly fit the resident, promote resident comfort, ease of use, dignity and good skin integrity, promote continued independence whenever possible and are appropriate for the time of day, and for the individual resident's type of incontinence. It was determined through assessment that the most appropriate product to fullfil the requirement above, for resident #007 was a specified product. The licensee permitted the resident's representative to make a charge or accept a payment on the licensee's behalf for continence care products, which they received funding from the local health integration network under their service accountability agreement.

A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf.
The plan of care for resident #007 indicated that the resident was incontinent and required a specified product on all three shifts. Staff were to toilet the resident regularly each shift as specified. Observation of the closet card for this

resident on October 3, 2017, indicated that staff were to use a specified product for two shifts which were provided by the family. Interview with PSW staff #105 and #106 as well as the ADOC confirmed that the resident used a specified product supplied by the family. The ADOC confirmed that the resident was not offered a range of continence care products including the specified product supplied by the home; however, since the time of inspection, the home has been providing the resident with the specified product. (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 21st day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROL POLCZ

Service Area Office /
Bureau régional de services : Hamilton Service Area Office