Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 7, 2019	2019_546750_0013	015836-19, 017396-19, 017397-19	Critical Incident System

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

STACEY GUTHRIE (750), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 27, 30, 2019, October 1, 2, and 3, 2019.

The following intakes were completed during this Critical Incident inspection:
Log # 015836-19 related to falls,
Log # 017396-19 related to abuse,
Log # 017397-19 related to abuse.
The following intakes were completed concurrently in a Follow Up inspection:
Log # 006801-19 regarding 8(1) (b) CDD July 24, 2019,
Log # 006800-19 regarding 6(10), CDD July 24, 2019.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Food Service Manager (FSM), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspector(s) observed the provision of resident care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes, policies and procedures, and Critical Incident System (CIS) submission.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 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	Légende 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for resident #015 that set out the planned care for the resident.

A review of critical incident (CI) indicated alleged abuse by resident #013 to resident #015.

The home's CI internal documentation was reviewed as well as the written plan of care for resident #015. A progress note from a specified date, indicated resident #015 was assessed after the incident by registered staff with no findings, referrals were made, and physician, family and police were notified. Progress notes identified that the resident was being assessed on two identified dates at specified times. The Director of Care (DOC) acknowledged in an interview that resident was being monitored after the incident for 24 hours. The planned care, to monitor resident #015, was not reflected in the resident's written plan of care.

In an interview with the DOC #101, they confirmed that the planned safety interventions for resident #015 was not set out in the resident's written plan of care. [s. 6. (1) (a)]

Issued on this 7th day of October, 2019

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

Original report signed by the inspector.