Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Jan 22, 2020	2020_556168_0001	000219-20, 000549-20	Critical Incident System

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
5290 Yonge Street Suite 200 NORTH YORK ON M2N 5P9

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

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): January 15, 17, and 21, 2020.

This inspection was conducted related to Critical Incident System logs:
000219-20 - related to prevention of abuse and neglect; and
000549-20 - related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director or Care (DOC), assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses, Personal Support Workers, a physician and residents.

During the course of the inspection, the inspector observed the provision of care and services, reviewed video footage, reviewed records including but not limited to: policies and procedures, clinical health record and incident reports.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (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's plan of care was revised at any time when the resident's care needs changed, following an incident.

According to the clinical record resident #010 was involved in an incident on an identified date in 2020.
The resident was assessed, by RN #106 and was noted to have specific assessment findings.
Treatment was administered and the physician and substitute decision maker were notified of the resident's condition.
The physician directed staff to continue with the assessments in place.
The following shift, RN #104 continued to monitor and assess the resident. The assessments noted a change in some specific findings.
The resident was found with a significant change in condition later that shift.
The resident's plan of care was not revised with the changes in their care needs which were identified by the assessments.
Interview with the physician confirmed that they were not informed of the resident's change in status.
Interview with RN #104 confirmed that they did not take action related to the resident's change in assessment findings, although did administer a treatment.

The resident's plan of care was not revised with changes in their care needs following an incident. [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 resident's plan of care is reviewed and revised at any time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were implemented to respond to the resident who demonstrated responsive behaviours, where possible.

Resident #011 was admitted to the home on an identified date in 2019, with a cognitive status and some known behaviours, according to the progress notes.
A referral was submitted to Behavioural Supports Ontario (BSO) for transitional support on admission.
The resident displayed additional behaviours, some as early as the day after admission until an identified date.
Following the display of the additional behaviours, the resident was reassessed by BSO, eight days later, who suggested interventions in an effort to manage and to rule out a potential condition.
The resident continued to demonstrate behaviours and eight days later, was reported to be involved in an interaction with a co-resident which was not desired.
Later that day, the home initiated actions to implement the interventions as suggested by the BSO.
Interview with the DOC identified that the purpose of referrals to BSO, when a resident demonstrated responsive behaviours was to assist in the development of interventions to manage the resident's responsive behaviours. They confirmed that the BSO identified interventions; however, they were not implemented initially, nor was there documentation to identify why the interventions were not implemented.

Strategies were not implemented to respond to the resident who demonstrated responsive behaviours. [s. 53. (4) (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 strategies are developed and implemented to respond to the resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

i. According to the clinical record resident #010 displayed a symptom on an identified date in 2020 and a medication was administered by RN #104.
A review of the physician's orders included a Medical Directive for the medication at a specified dosage and a specified route as needed for specific symptoms.
A review of the January 2020, electronic Medication Administration Record (eMAR) included documentation that the resident was administered the medication on the identified date, by RN #104.
Interview with RN #100 identified that the home did not have the medication at the desired dosage and route in the home.
Interview with RN #104 confirmed that they only administered half of the dosage of the medication as prescribed as the home did not have the medication at the prescribed dosage even though it was part of the current Medical Directives.

ii. Resident #016 received an order for a medication, to be administered once a day, on a specified date in December 2019, as documented by RN #106 in the "Prescriber Order Sheet" as a T.O. (telephone order) from the physician.
A review of the January 2020, eMAR did not include the medication.
The eMAR and clinical record were reviewed by RN #100 who verified that the order, in error, was not processed and for this reason the resident did not receive the medication as ordered.

The medications were not administered as prescribed. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 22nd day of January, 2020

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

Original report signed by the inspector.