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

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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
Dec 3, 2020	2020_556168_0021	011840-20, 014923-20, 020834-20	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): November 24, 25, 26 and 30, 2020.

This inspection was conducted related to Critical Incident System (CIS) intakes, each related to falls prevention and management.

Log number 011840-20 for CIS 2720-000009-20.
Log number 014923-20 for CIS 2720-000011-20.
Log number 020834-20 for CIS 2720-000014-20.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the acting Director of Nursing, the acting assistant Director of Nursing, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector observed the provision of care, reviewed relevant records including but not limited to: training records, policies and procedures and clinical health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others who were involved in the different aspects of care collaborated with each other in the assessment of residents so that their fall risk assessments were integrated, consistent with and complemented each other.

i. According to the clinical record a resident had a fall risk assessment completed which identified a fall risk level.
The assessment identified that the resident did not have a secondary diagnosis.
A review of the medical record noted that the resident had at least two diagnoses since their admission.

A second fall risk assessment was completed which identified that they were at higher fall risk level than previously recorded.
The assessment identified that the resident had a history of falls.
The previous assessment did not include a history of falls and another assessment noted that the resident did not have any falls in the past 180 days.
The assessments were not integrated, consistent with and did not complement each other.
Assessments need to be integrated, consistent with and complement each other to assist in accurate planning for the resident's care needs.

ii. A second resident was at a risk of falls according to the falls risk assessment.
The assessment identified that the resident did not use any ambulatory aid(s).
The care plan included an intervention that the resident used a mobility aid.
The assessments were not integrated, consistent with and did not complement each other.
Assessments need to be integrated, consistent with and complement each other to assist in accurate planning for the resident's care needs.

Sources: Plan of care and assessments for residents and interviews with staff. [s. 6. (4) (a)]

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 staff and others who are involved in the different aspects of care collaborate with each other in the assessment of residents so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures in the required Pain Management program were complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 4 the licensee was required to have an interdisciplinary Pain Management program and in accordance with O. Reg. 79/10, s. 52 (1) 4, the licensee was required to ensure the monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The home's procedure Pain and Symptom Management, LTC RCM G 30.10 effective January 2015, directed registered staff to conduct and document a pain assessment electronically when there was an acute change in condition with onset of pain and when pain management strategies were ineffective.

i. A review of the clinical record noted that a resident had a fall and the next day demonstrated signs of discomfort.
A diagnostic test suggested an injury, at which time routine pain medication was ordered to be given four times a day.
The resident did not have pain assessments consistently completed, despite documented symptoms and an injury.
The completion of pain assessments provides a consistent method of assessment and assists in accurate planning for the resident's care needs.

ii. A second resident had long standing complaints of pain, prior to their admission to the home.
The physician was notified and orders were received to assist in the management of their pain.
The clinical record did not include a pain assessment at the time of the increased reports of pain, which were treated when the previous strategies were no longer effective.
The completion of pain assessments provides a consistent method of assessment and assists in accurate planning for the resident's care needs.

Sources: Progress notes, physician's orders and pain assessments for residents and interviews with staff. [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 procedures in the required programs are complied with, 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 a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

According to the clinical record a resident had a fall.
The resident had orders for a pain medication every four hours as needed for fever or pain.
The following day the resident presented with signs of discomfort with movement.
Approximately 24 hours after the fall the resident had symptoms of pain and as needed pain medication was given with effect.
Over the next three days the resident continued to display symptoms which could be suggestive of pain, which were managed with interventions, not including pain medication.
Pain medication was not given following the fall, with the exception of on one occasion, despite documentation which suggested symptoms of discomfort.
The medication, ordered for pain, was not included on the record for administration until approximately 24 hours after it was prescribed.
Staff who worked with the resident following the fall identified that in their opinion, the resident did not present with pain.
The medication was not administered in accordance with the directions for use specified by the prescriber.
Failure to administer medications as ordered may result in additional discomfort for the resident.

Sources: The clinical record for the resident and interviews with staff. [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 4th day of December, 2020

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

Original report signed by the inspector.