Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Hamilton Service Area Office**
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137
hamiltondistrict.mltc@ontario.ca

# Original Public Report

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|---|---|
| **Report Issue Date:** November 14, 2022 | |
| **Inspection Number:** 2022-1216-0001 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident System | |
| **Licensee:** Hardy Terrace LTC Operating Limited | |
| **Long Term Care Home and City:** Hardy Terrace, Brantford | |
| **Lead Inspector**<br>Jennifer Allen (706480) | **Inspector Digital Signature**<br>Jennifer L Allen<br>Digitally signed by Jennifer L Allen<br>Date: 2022.11.15 13:13:46 -05'00' |
| **Additional Inspector(s)**<br>Barbara Grohmann (720920)<br>Dusty Stevenson (740739) | |

## INSPECTION SUMMARY

The Inspection occurred on the following date(s):
**October 5 - 7, 11 – 14, 17 - 19, 2022.**

The following intake(s) were inspected:

- Intake: #00002796-[CI: 2720-000005-22] Fall of a resident resulting in injury.
- Intake: #00003237- STAFFING - Complaint with concerns regarding neglect, personal support services related to short staffing and care needs of residents not being met.
- Intake: #00003867-[CI: 2720-000004-21] Fall of a resident resulting in an injury.

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

- **Infection Prevention and Control**
- **Falls Prevention and Management**
- **Prevention of Abuse and Neglect**
- **Staffing, Training and Care Standard**

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Maintenance Services

**NC # 01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O.Reg. 246/22, s. 96 (2) (b)

The licensee has failed to ensure that procedures were developed and implemented to ensure that a resident's bed alarm was kept in good repair to support their falls prevention plan.

**Rationale and Summary**

A resident had an unwitnessed fall from bed and was found on the floor while attempting to self-transfer. Their bed alarm was not functioning at the time of the fall, and their chair alarm was in place on their wheelchair.

As per staff, the bed alarm for the resident was often not in working order and confirmed that this was reported to registered staff. Staff also stated that when the bed alarm was not functioning, the chair alarm was used in its place.

The Falls Lead and DOC confirmed that if a bed alarm is not in working order, it should be reported to registered staff and replaced as soon as possible. Falls Lead and DOC confirmed that if a bed alarm was not available, a chair alarm was an acceptable substitute.

Failure to have a functioning bed alarm in place or an acceptable substitute (chair alarm) resulted in staff not being alerted to the resident's attempted self-transfer and subsequent fall, causing pain to the resident.

**Sources:** resident progress notes; interviews with staff, the Fall Lead and the DOC.
[740739]

## WRITTEN NOTIFICATION: Fall

**NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
**Non-compliance with: O.Reg. 246/22, s. 54 (2).**

The home failed to ensure that when resident sustained a fall, they were assessed and a clinically appropriate assessment instrument that is specifically designed for falls was used.

**Rationale and Summary**
The home required that specific post fall assessments be completed by the registered staff following any fall.

The Fall Lead acknowledged, when the resident fell, the required post fall documentation was not completed, and an audit conducted by the Fall Lead following the fall confirmed the documentation was not completed.

Staff stated that following any fall, specific post fall documentation should be completed. The DOC confirmed it is the home's expectation that there should be specific post fall assessments completed after each fall.

Failure to assess the resident may have increased the risk of harm relating to having unidentified injuries or delay in obtaining appropriate treatment.

**Sources**: Falls - Resident Policy (Last revised: August 18, 2021), resident online assessments and progress notes and interviews with the DOC, the Fall Lead and other staff.
[706480]

## WRITTEN NOTIFICATION: Bathing

**NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
**Non-compliance with: O.Reg. 246/22, s. 37.**

The licensee failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice.

**Rationale and Summary**
A resident was identified by the staff to be scheduled for a bath at the frequency of twice a week and the plan of care noted physical assistance was required for the bathing activity.

Review of the bathing records identified the resident had multiple times where they refused a bath from the staff. Their plan of care for bathing stated if the resident was refusing a tub bath then a bed bath should be provided. There were no nursing progress notes, supporting that the resident received their two baths a week during the inspected time frame.

According to the Bathing Policy each resident is to bathed twice a week, and the registered staff in the event that a bath was not provided as scheduled, will follow up and provide another bath date as an alternative to

make-up the missed bath.

Staff identified that the resident frequently refused baths and could not confirm that make-up baths were offered and provided during the specific time frame to meet the twice a week bathing requirement.

The DOC confirmed it was the home's expectation that each resident was to receive two baths a week and if a resident refuses to try to offer and document the attempt to make up the bath in the system.

**Sources**; Bathing Policy (Last revised March 15, 2022): resident's bathing record and progress notes, Interviews with the DOC and other staff.
[706480]

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