Ontario

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

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: March 24, 2023
Inspection Number: 2023-1216-0002
Inspection Type: Complaint Critical Incident System
Licensee: Hardy Terrace LTC Operating Limited
Long Term Care Home and City: Hardy Terrace, Brantford

Lead Inspector	**Inspector Digital Signature**
Yvonne Walton (169)	Yvonne Walton Digitally signed by Yvonne Walton Date: 2023.05.29 11:08:02 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s), March 10, 13-16, 20, 23, 2023.

The following intake(s) were inspected: • Intake: #00001481 - Improper/Incompetent treatment of resident.
- Intake: #00005694 - Financial abuse to resident
- Intake: #00008538 and #00021224 - Fall of resident resulting in injury.
- Intake: #00017111 - Home denying application for admission.
- Intake: #00018828 - Controlled Substance missing/unaccounted.

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

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary

In August 2022, the resident received an intervention that was not in their plan of care.

Sources
A review of the plan of care confirmed there was no direction to provide the intervention.
Interview with Registered Practical Nurse (RPN), Personal Support Worker (PSW), Director of Care and the Administrator.

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