Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 19, 2013	2013_205129_0011	H-000091-13	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

PHYLLIS HILTZ-BONTJE (129)

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): August 16 and 19, 2013

This critical incident inspection was conducted concurrently with three complaint inspections. (Inspection #2013_205129_0010). Non-compliance related to this critical incident inspection has been issued on the complaint inspection report and includes: SEE COMPLAINT REPORT FOR COMPLETE DETAILS
LTCHA 6(10)b - the resident was not reassessed and the plan of care was not reviewed and revised when the care needs of the resident changed - issued as a Compliance Order
Regulation79/10 26(3)5 - the plan of care was not based on an interdisciplinary assessment of behaviours - issued as a Compliance Order
Regulation 79/10 26(3)10 - the plan of care was not based on an interdisciplinary assessment of falls, risk of injury from bleeding, pain and seizures
Regulation 79/10 229(1)1- residents must be screened for tuberculosis within 14 days of admission.

During the course of the inspection, the inspector(s) spoke with regulated and unregulated nursing staff, the Assistant Director of Care and the Administrator, in relation to Log # H-000091-13.

During the course of the inspection, the inspector(s) reviewed clinical records and reviewed the home's policy Tuberculosis Screening

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the Director was immediately notified of an unexpected sudden death that was the result of an accident in the home, in relation to the following: [107(1) 2]
Staff in the home did not immediately notify the Director of the sudden death of resident #003 subsequent to a incident in the home. Staff #101 confirmed that resident #003 was admitted on an identified date in 2012 and the disease processes affecting this resident as well as the resident's condition did not lead staff to expect the resident's eminent death. Staff and clinical documentation confirmed that on and identified date in 2013 an incident occurred in the home which resulted in signifcant injuries for which the resident was transferred to the hospital for assessment and treatment. Staff and clinical documentation also confirmed that staff from the hospital contacted the home and informed the home latter the same day and indicated the resident died. The home did not notify the Director of this sudden unexpected death until the following day. [s. 107. (1) 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 and ensuring that the Director is immediately notified of an unexpected or sudden death resulting from an accident, to be implemented voluntarily.

Issued on this 19th day of December, 2013

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

P. Hiltz-Bontje