Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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119, rue King Quest, 11iém étage
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
January 12, 2011	2011_192_2720_12Jan101628	Critical Incident H - 02141

Licensee/Titulaire
Diversicare Canada Management Services Co. Inc.,2121 Argentia Road, Suite 301, Mississauga, Ontario, L5N 2X4

Long-Term Care Home/Foyer de soins de longue durée
Hardy Terrace, 612 Mount Pleasant Road, RR#2, Brantford, Ontario, N3T 5L5

Name of Inspector(s)/Nom de l'inspecteur(s)
Debora Saville Nursing Inspector #192

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with: Assistant Director of Resident Services, Registered Nurses, Registered Practical Nurses, Personal Support Workers and resident.

During the course of the inspection, the inspector: observed staff interaction with residents, reviewed the specified residents medical records.

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

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
1 VPC
1 CO #001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Réglsseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(1)(c

Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident.

Findings:

A specified resident sustained injuries that resulted in changes to the care needs of the resident, the plan of care was updated. Direction within the plan of care is not consistent or current and does not provide clear direction for staff.

During review of the plan of care it is noted that:

i) Under transferring for the specified resident the care plan indicates "No weight bearing", sling lift only. Under toileting the plan of care indicates extensive assistance, weight bearing support, full staff performance, two person physical assist. No lift is indicated for use. Under Falls/Balance the plan of care indicates, ensure the resident has a specific device in place for all attempts at ambulation and transfer. A walker is available at the specified resident's bedside. No clear, consistent direction is provided to staff for the safe transfer of the resident.

ii) It was identified during interview with a PSW that a specified resident does not wear a seat belt in the wheelchair. The plan of care indicates under safety devices/restraints that a seat belt is used daily in the wheelchair. There is a front closing seat belt attached to the wheelchair. There is consent for front closing seat belt on the resident's medical record. The Annual Conference indicates the resident "has an order for a front closure seat belt in chair for safety and to maintain position." No order for a seat belt is found in a review of the physician orders.

iii) The plan of care for the specified resident identifies that a specialized chair is to be utilized when out of bed and that a restraint is not required while in the specialized chair. During interview with a PSW it was identified that the resident sits in their own wheelchair. A wheelchair with attached front closing seatbelt was observed at the resident's bedside.

Inspector ID #:	Nursing Inspector # 192

Additional Required Actions:
CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(10)(b)

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,

(b) the resident's care needs change or care set out in the plan is no longer necessary;

Findings:

A specified resident sustained an injury, the care needs changed significantly at that time and the plan of care was updated. Since then, the resident has had successful healing, the wheelchair has been repaired and the needs have again changed. The plan of care has not been updated to provide consistent direction on the transfer, seating, and seat belt needs for this resident.

During review of the plan of care it is noted that:

i) It was identified during interview with a PSW that the specified resident does not wear a seat belt in her chair. The plan of care indicates under safety devices/restraints that a seat belt is used daily in the wheelchair.

ii) The plan of care for the specified resident identifies that a specialized chair is to be utilized when out of bed and that a restraint is not required while in the specialized chair. During interview with a PSW it was identified that the resident sits in their own wheelchair. A wheelchair with attached front closing seatbelt was observed at the resident's bedside.

Inspector ID #:	Nursing Inspector #192

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 ensuring that a specified resident (and all other residents within the home), is assessed and the plan of care reviewed and revised to reflect the current needs of the resident, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Revised for the purpose of publication - Sept 29, 2011
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**		
Name of Inspector:	Debora Saville	**Inspector ID #**	192
Log #:	H- 02141		
Inspection Report #:	2011_192_2720_12Jan101628		
Type of Inspection:	Critical Incident Inspection		
Date of Inspection:	January 12, 2011		
Licensee:	Diversicare Canada Management Services Co. Inc., 2121 Argentia Road, Suite 301, Mississauga, Ontario, L5N 2X4		
LTC Home:	Hardy Terrace, 612 Mount Pleasant Road, RR#2, Brantford, Ontario, N3T 5L5		
Name of Administrator:	Paul Rooyakkers		

To Hardy Terrace you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)]

Pursuant to: The Licensee has failed to comply with the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(1)(c

Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident.

Order:

The licensee shall update the plan of care for a specified resident to ensure it provides clear direction to staff related to the use of a seatbelt, mobility and transferring of this resident and shall ensure that the plan of care for each resident in the home provides clear direction to staff on the current needs of that resident.

Grounds:

A specified resident sustained injuries that resulted in changes to the care needs of the resident, the plan of care was updated. Direction within the plan of care is not consistent or current and does not provide

clear direction for staff.

During review of the plan of care it is noted that:

i) Under transferring for the specified resident the care plan indicates "No weight bearing", sling lift only. Under toileting the plan of care indicates extensive assistance, weight bearing support, full staff performance, two person physical assist. No lift is indicated for use. Under Falls/Balance the plan of care indicates, ensure the resident has a specific device for all attempts at ambulation and transfer. A walker is available at the specified resident's bedside. No clear, consistent direction is provided to staff for the safe transfer of the resident.

ii) It was identified during interview with a PSW that a specified resident does not wear a seat belt in the wheelchair. The plan of care indicates under safety devices/restraints that a seat belt is used daily in the wheelchair. There is a front closing seat belt attached to the wheelchair. There is consent for front closing seat belt on the resident's medical record. The Annual Conference indicates the resident "has an order for a front closure seat belt in chair for safety and to maintain position." No order for a seat belt is found in a review of the physician orders.

iii) The plan of care for the specified resident identifies that a "fallout" chair is to be utilized when out of bed and that a restraint is not required while in the "fallout" chair. During interview with a PSW it was identified that the resident sits in their own wheelchair. A wheelchair with attached front closing seatbelt was observed at the resident's bedside.

This order must be complied with by:	Immediately

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this day of , 2011. - Revised for the purpose of publication - Sept 29, 2011	
Signature of Inspector:	Verbal for D Saville
Name of Inspector:	Debora Saville
Service Area Office:	Hamiltion Service Area Office 119 King St. West, 11th Floor Hamilton ON L8P 4Y7