Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 9, 10, Aug 23, Oct 31, Nov 1, 2011	2011_027192_0027	Critical Incident

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care related to H-001106-11.

During the course of the inspection, the inspector(s) reviewed medical records and policy and procedure.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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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.) 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 subsections:

s. 6. (10) 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,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change.
a) The plan of care for a specified resident does not include interventions related to falls, in spite of a history of falls. The resident sustained an unwitnessed fall. The plan of care was not revised following this fall to include interventions related to fall management and injury prevention. The resident sustained a subsequent fall that resulted in transfer to hospital with injury.

b) A specified resident fell sustaining injuries that resulted in her transfer to hospital.
A late entry related to the post fall assessment was made by the Registered Practical Nurse responsible for the resident's care indicates that the resident was in pain post fall. There was no further assessment or reassessment of this pain. Vital signs were not documented and reassessment was not conducted throughout the night shift. There is no indication of pharmacological or non-pharmacological interventions to promote comfort for the resident.

c) A specified resident was being treated for a respiratory infection and had been started on antibiotic. Monitoring and vital signs related to this change in health were not documented in the medical record at the time signs and symptoms were first observed or at any other time. There is no indication in the plan of care that this resident was on infection control precautions. The plan of care was not updated with this change in condition.

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 staff and others involved in different aspects of care of the resident collaborate with each other in the assessments of residents so that assessments are integrated and are consistent with and compliment each other; that the resident is reassessed and the plan of care reviewed and revise when the resident's care needs change, 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The homes policy on Fall Prevention and Management (NM-II-F005) dated December 2009 indicates that residents who experience a fall should be assessed, first aid initiated as appropriate and the resident moved to the bed for further assessment, using a mechanical lift.
Documentation indicates that the specified resident was assisted from the floor following two falls, with the assistance of two staff, no lift was used.

The homes policy on Fall Prevention and Management (NM-II-F005) dated December 2009 indicates that head injury routine should be implemented following a fall if trauma to the head was suspected, the resident is on anticoagulant therapy or if it was an unwitnessed fall.
A specified resident sustained two unwitnessed falls. No head injury routine was initiated.

The homes policy on Fall Prevention and Management (NM-II-F005) dated December 2009 indicates that, post fall, staff are to plan and implement corrective actions immediately e.g. bed rail, bed/chair alarm, proper footwear, monitoring protocol, etc.
A specified resident sustained multiple falls. The plan of care in effect at the time of the falls does not provide interventions to prevent falls, or minimize injury related to falls for this resident.

The homes policy on Fall Prevention and Management (NM-II-F005) dated December 2009 indicates that the fall is to be reported to the multidisciplinary team to ensure proper follow-up. There is no documentation of referral to members of the multidisciplinary team to secure follow-up assessment of a specified resident following a fall.

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 where the Act or Regulation require the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, strategy or system, it is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. A specified resident sustained two falls. Following each fall, documentation indicates that staff lifted the resident from the floor using two staff members without use of a mechanical lift.
The Fall Prevention and Management Policy (NM-II-F005) indicates that residents should be assessed, then using a mechanical lift, move to the bed to proceed with further assessment.

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.
A specified resident sustained an unwitnessed fall. Documentation in the progress notes indicates that the resident sustained redness to the right upper back along the shoulder blade area. No post fall assessment is available in the medical record for this fall.
2. The specified resident sustained a subsequent fall. A Post Fall Investigation form was initiated by the Registered Practical Nurse on duty but does not include vital signs or documentation related to a physical assessment completed post fall. No other documentation of assessment or reassessment was recorded in the medical record at the time of the incident or until the day staff assessed the resident, at which time it was noted that the specified resident had sustained an injury.

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. A specified resident sustained a fall that resulted in a transfer to hospital with injury.
The fall resulting in injury with hospitalization was not reported to the Director for four days. Reporting is required within one business day of the licensee becoming aware of the incident with full report within 10 days of becoming aware of the incident.

Issued on this 1st day of November, 2011

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