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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 23, Sep 26, 2016	2016_275536_0014	021025-16	Resident Quality Inspection

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

CATHIE ROBITAILLE (536), CAROL POLCZ (156), MELODY GRAY (123), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 20, 21, 22, 25, 26, 27, 28, 29, August 2, 3, 4, 5 and 8, 2016.

The following inspections were completed concurrently with the RQI:

Complaints:

035638-15-related to staffing hours
002544-16-related to missing clothing and care

Critical Incident System:

001568-16-related to elopement from facility
019930-16-related to elopement outside of facility
005077-16-related to falls
007689-16-related to falls
017471-16-related to responsive behaviours and discharge
021172-16-related to falls and skin and wounds

Follow ups:

003279-16-related to transferring and positioning
003280-16-related to pain management
003281-16-related to prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with residents, family members, recreation staff, restorative and physiotherapy staff, dietary staff, Food Service Supervisor (FSS), housekeeping staff, Maintenance, Bookkeeper, personal support workers (PSW), registered Staff, Resident Assessment Instrument (RAI) Co-Ordinator, Assistant Director of Resident Care (ADORC), Director of Resident Care (DORC) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed meal and snack services, observed the provision of care and services provided on all home areas, interviewed staff, residents and families, and reviewed relevant documents including, health care records, investigation reports, training records, meeting minutes, menus, health care records, resident trust accounts and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 134.	CO #002	2015_267528_0026	536
LTCHA, 2007 s. 19. (1)	CO #003	2015_267528_0026	536
O.Reg 79/10 s. 36.	CO #001	2015_267528_0026	536

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

A. A review of the plan of care which the home refers to as the care plan for resident #008, identified that the resident required limited assistance of one staff for bed mobility. A review of the most recent Minimum Data Set (MDS) assessment stated that the resident required extensive assistance and one person physical assist. The Resident Assessment Instrument (RAI) Co-ordinator confirmed that records in the resident's plan of care were not integrated and consistent with MDS coding.

B. A review of the plan of care which the home refers to as the care plan for resident #013 identified that the resident required the assistance of one staff for toileting. A review of the most recent MDS assessment, stated that the resident was totally dependent requiring two person physical assistance. The RAI Co-ordinator confirmed that records in the resident's plan of care were not integrated and consistent with MDS coding.

C. A review of the plan of care which the home refers to as the care plan for resident #012 identified that the resident required limited assistance of one staff for toileting. A review of the most recent MDS assessment stated that the resident required extensive assistance of one person physical assist for toileting. The RAI Co-ordinator confirmed

that records in the resident's plan of care were not integrated and consistent with MDS coding. [s. 6. (2)]

2. The licensee has failed to ensure that the care set out in the plans of care was provided to residents as specified in the plans.

A. The plan of care for resident #050 indicated that the resident required total feeding assistance. During the observed lunch meal on an identified date, the resident was observed with food in front of them for an identified period without any assistance or encouragement from the personal support worker(PSW) staff.

B. The plan of care for resident #051 indicated that the resident ate poorly, and required extensive encouragement to eat even half of the meal on most days. During the observed lunch meal on an identified date, the resident was observed with food in front of them for an identified period of time without any assistance or encouragement from the PSW staff.

C. The plan of care for resident #052 indicated that the resident required supervision and cueing throughout the meal due to cognitive impairment. During the observed lunch meal on an identified date, the resident was observed asleep at the table with food in front of them for an identified period of time without any assistance, encouragement or attempt to wake by the PSW staff.

Care set out in the plan of care was not provided to the above residents as specified in the plans. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A review of the plan of care, which the home refers to as the care plan for resident #008, identified that the resident was using a walker when walking with the restorative staff in the corridors. A review of the progress notes during a specified time, identified that the resident was discharged from the restorative mobility program. When interviewed staff # 127 and staff #126 confirmed that the resident did not use a walker for locomotion walk in the corridor. [s. 6. (10) (b)]

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 care set out in the plans of care was provided to residents as specified in the plan. This voluntary plan of compliance applies to 6(7) only. 6(2) and 6(10)(b) were issued as WN's, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home.

A. The clinical record of resident #023 was reviewed and it was noted, that the resident returned from the hospital on a specified date in 2016 with altered skin integrity. A referral to the home's registered dietitian (RD) for the assessment of the wounds was not completed until a specified date in 2016. The food services supervisor (FSS) was interviewed and confirmed that a referral for the RD related to altered skin integrity was not completed a specified date in 2016.

B. Resident #014 was identified as having a stage 1 pressure ulcer. A review of the clinical record and interviews with staff #127 and #103, identified that a referral would not be made to the registered dietitian for residents with stage 1 pressure ulcers. The home's policy, "Skin and Wound Care Management Protocol", Policy No: LTC-RCM-G-10-80, effective date, January, 2015, directed the Skin Care Coordinator/Resource Nurse on page one to conduct weekly wound and skin care rounds with the registered staff assessing pressure wounds stage 2 or greater. The policy then stated on page one to ensure the registered dietitian (RD) was referred to assess residents with wound care needs. During interview with staff #103 they confirmed, that only stage 2 or greater would be referred to the RD. However, on page three of the policy it directed the registered dietitian to assess residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds. The Director of Resident Care (DORC) confirmed that the policy did not give clear direction to staff or the dietitian. The home failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by the registered dietician who is a member of the staff of the home. 536 [s. 50. (2) (b) (iii)]

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 resident's who are exhibiting altered skin integrity are assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #033's plan of care was based on, at a minimum, interdisciplinary assessment of pain.

A review of resident #033's electronic medication administration record (EMAR) identified that the resident had been started on pain medication on a specified date in 2016. The plan of care for resident #033 which the home refers to as the care plan did not identify that the resident had pain, or why they were being treated for pain. This was confirmed by the Resident Assessment Instrument (RAI) Co-Ordinator. [s. 26. (3) 10.]

2. The licensee has failed to ensure that the plan of care for resident #007 was based on, at a minimum, interdisciplinary assessment with respect to the resident's dental status.

During stage one of a family interview, the family member when asked about any concerns with residents teeth or dentures, identified that resident #007 had issues with eating certain foods due to loose fitting dentures. An interview with staff #106 and #116, identified that at times resident had issues with their dentures. During interview with resident #007, they stated the residents dentures were loose. A review was completed of resident #007's clinical record and it did not identify any issues with loose fitting dentures. This was confirmed by the staff #106. A review of the homes policies provided to the inspector addressing dental care and assessments did not include any type of assessment for loose fitting dentures. This was confirmed by staff #103. [s. 26. (3) 12.]

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 residents plan of care are based on, at a minimum an interdisciplinary assessment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

A. On July 20, 2016 during initial tour of the home, it was noted that a specified spa room door did not close and lock without being pulled shut. At that time it was brought to the attention of the Administrator who had the maintenance department re-adjust the door closure.

B. On July 28, 2016 it was once again noted, that the door of a specified spa room did not close and lock without being pulled shut. Noted in the room behind an unlocked door was a bottle of virex disinfectant. That same day it was also noted, that another specified spa room door did not close and lock without being pulled shut. Noted in the room sitting on the sink was a bottle of disinfectant.

The Administrator confirmed the doors to the spa rooms were to be locked at all times. [s. 9. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the programs included a weight monitoring system to measure and record with respect to each resident, body mass index and height upon admission and annually thereafter.

A reviewed of resident's height & weight summary identified that there were 17 residents out of randomized sample of 40 (42.5%), whose heights were not measured and recorded on annual basis by the home's staff. Staff #107 when interviewed confirmed that residents' heights were measured in a home upon their admission. Staff #127 and Resident Assessment Instrument (RAI) Co-ordinator, confirmed that heights for the residents were to be done upon admission and annually. [s. 68. (2) (e) (ii)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight changes that compromises the resident's health status.

A review of the plan of care which the home refers to as the care plan contained no nutrition assessment for a specified date in 2016, related to significant weight loss over one, three and six months for resident #008, who was at high nutrition risk. Staff #114 when interviewed confirmed that significant weight changes were to be recorded and reported to the registered staff. Staff #113 when interviewed confirmed that once they were informed about significant weight changes, they were to complete an initial assessment in relation to resident's health status and then a referral was to be sent to the registered dietitian (RD). Staff #133 when interviewed confirmed that no referral and nutrition assessment was recorded in the resident's plan of care for resident #008. The RD when interviewed also confirmed that the resident with significant weight changes was not assessed using an interdisciplinary approach. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

During the lunch meal observation in an identified dining room on a specified date in 2016, the therapeutic menu indicated that puree textured veggie sticks with dip was to be available for those on a puree textured diet as the alternate choice of vegetables. As confirmed with dietary staff #100, there was no alternate puree vegetable offered or available during the lunch meal on this date. [s. 71. (4)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident they ensure that alternatives to discharge had been considered.

On a specified date in 2016, resident #041 was sent to the hospital following an altercation with another resident. The following day the home's physician discharged the resident refusing them return to the home. An interview with the Administrator confirmed that alternatives to discharge had not been considered. [s. 148. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participates in the implementation of the infection prevention and control program.

A. On July 20, 2016 during initial tour of the home it was noted in a specified spa room, one unlabeled, used hair brush. The Director of Resident Care (DORC) confirmed that these items are to be labelled to ensure they are used only on one resident.

B. On July 20, 2016 during initial tour of the home it was noted in a specified spa room, one unlabeled, used hair brush. The DORC confirmed that these items are to be labeled to ensure they are used only on one resident.

C. On July 28, 2016 in was noted in a specified spa room, one unlabeled open stick deodorant as well as an unlabeled nail clipper. The Administrator confirmed that these items are to be labeled to ensure they are used only on one resident. [s. 229. (4)]

2. The licensee has failed to ensure that staff screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The record of an identified employee was reviewed and it indicated that the staff member was not screened for tuberculosis. The home was requested to provide documentation to demonstrate that the staff member was screened for tuberculosis. The home was not able to provide documentation to demonstrate that the staff was screened for tuberculosis, in accordance with evidence-based practices, and if they are none, in accordance with prevailing practices. [s. 229. (10) 4.]

Issued on this 26th day of September, 2016

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

Original report signed by the inspector.