Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 5, 2020	2020_558123_0001	010405-20	Complaint

Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
5290 Yonge Street Suite 200 NORTH YORK ON M2N 5P9

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

MELODY GRAY (123), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 9, 10, 11, 12, 15, 16, 17, 18, 19, 23, 24, 25, 26, 29 & 30, 2020.

The following intake was included in this off-site inspection:
Complaint # 010405-20 related to skin and wound care, alleged neglect and reporting and complaints.

During the course of the inspection, the inspector(s) spoke with registered staff, the Food Services Supervisor, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

During the course of this inspection, the inspector reviewed the home's records including, policies and procedures and reviewed residents' health records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

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	Légende 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

On an identified date in May 2020, the Ministry of Long-Term Care (MLTC) received a complainant from a staff member, indicating they sent an email letter to the management of the home, expressing concern about the care of provided to resident #001. In the email letter, they also alleged resident #001 was neglected.

The Assistant Director of Care (ADOC) and the Director of Care (DOC) were interviewed and they reported the ADOC received the email letter on an identified date in May 2020, and conducted an investigation. They provided a copy of the email letter and the investigation record to the Inspector. The email was also noted to have been sent to the Administrator at a later date.

The ADOC and the DOC confirmed the home did not report the alleged neglect of the resident that resulted in harm or risk of harm, and the information upon which it was based to the Director. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home: a response was provided within 10 business days of receipt of the complaint.

On an identified date in May 2020, an email complaint was sent to the ADOC which included care concerns and alleged neglect of resident #001.
Review of the email complaint and the home's investigation notes did not include a documented response to the complainant (within 10 days).

The ADOC and the DOC were interviewed. The ADOC confirmed they received the email

and that the investigation was immediately completed. The DOC confirmed they had contact with the complainant after the investigation was competed but a response was not provided within 10 business days of the ADOC receiving the complaint. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record is kept in the home that included:
(a) the nature of each verbal or written complaint
(c) the type of action taken to resolve the complaint
(d) the final resolution, if any
(e) a description of the response, and
(f) any response made by the complainant

The home's February, March and May 2020, Complaint Records were reviewed which outlined the date the complaint was received; who made the complaint; whether the complaint was verbal or written; whether the receipt of the complaint was acknowledged; name of investigator; status of the investigation; whether external agencies were notified and date; whether the complainant was advised/letter sent and date the complaint was closed including initials of the staff.

The review of the Complaint Record included a verbal complaint received by the home on an identified date in February 2020, which was documented to have been resolved on two days later; however, it did not include the issue the individual complained about, the response they were provided and whether there was a response made by the complainant.

The DOC confirmed the documented record kept in the home did not include the nature of each written complaint; the type of action taken to resolve the complaints; the final resolution, if any; a description of the response and any response made by the complainant. [s. 101. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training was to be provided to all staff who provide direct care to residents: 2. Skin and wound care.

The home's 2019 Annual Record Review, which included the skin and wound care training attendance record was reviewed and it indicated 29 registered staff attended the training. No other direct care staff were documented on the attendance record for the training. The home's nursing and personal care services staffing list was also reviewed and indicated there were 63 staff working in the department.

The ADOC and the DOC were requested to provide documentation confirming that in 2019, all staff who provided direct care to residents received skin and wound care training and it was not provided. [s. 221. (1) 2.]

Issued on this 6th day of August, 2020

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

Original report signed by the inspector.