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
Jan 16, 2013	2013_188168_0005	H-00985-12	Complaint

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

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): January 15, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Nurse Manager, Environmental Supervisor, registered nurses, non-regulated care providers and residents.

During the course of the inspection, the inspector(s) observed the care and services provided to residents and the availability of supplies, reviewed an identified residents clinical record and reviewed relevant policies and procedures and audit tools.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Minimizing of Restraining
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee did not ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufactures' instructions.

Resident #01 has a "Nurse Assist" bed alarm system to alert staff when they are attempting to exit the bed.

On January 15, 2013, it was observed that the "Nurse Alert" bed alarm systems for residents #01 and #02 were set to a three second time delay.

Interview with the Director of Care and Nurse Manager confirmed that, in the home, all bed alarms should be set without delay, before the alarm is activated, to alert staff.

The instructions for use of the "Nurse Assist" system, as provided by the home, indicates that for operation staff are to "press TIME DELAY button until yellow light appears in window of desired setting".

Staff did not follow the manufactures' instructions by failing to set/reset the "time delay" button to ensure that there is not a delay of immediate signal notification when using the "Nurse Assist" system. [s. 23.]

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 to ensure that staff use all equipment and supplies in accordance with manufactures' instructions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

The plan of care for resident #01 identifies the use of two bedrails at all times when in bed to prevent self transferring. The resident was observed on January 15, 2013 to have two bedrails in the upright position when in bed.

The resident is not restrained in accordance with section 31 (or section 36) of the Act as there is no order or consent in place for the use of the device, there is no documentation to support staff monitoring, resident repositioning and reassessment of the resident when the bedrails are in use.

Interview with the Director of Care and Nurse Manager confirm the use of bedrails and that there is no order, consent or restraint flow sheets in place for this resident. [s. 30. (1)]

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 to ensure that no resident is restrained by the use of a physical device other than in accordance with section 31 or 36 of the Act, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS			
REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 72.	WN #2	2011_027192_0040	168
O.Reg 79/10 s. 72.	WN #1	2012_027192_0018	168

Issued on this 16th day of January, 2013

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

L Vink