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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Mar 11, 2016	2016_418615_0002	025373-15, 026815-15	Complaint

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF HURON
c/o Huronlea HFA 820 Turnberry Street South BRUSSELS ON N0G 1H0

Long-Term Care Home/Foyer de soins de longue durée

HURONLEA HOME FOR THE AGED
820 TURNBERRY STREET SOUTH BRUSSELS ON N0G 1H0

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

HELENE DESABRAIS (615)

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 19 and 20, 2015.

The two complaints inspections, Log #025373-15/IL-40350-LO and Log #026815-15/IL-40485-LO,IL-41948-LO and IL-42214-LO related to responsive behaviors, and altercations, and was conducted concurrently with the Resident Quality Inspection Log#024281-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care/RAI Coordinator/Behavioural Supports Ontario (BSO), a Registered Nurse, two Personal Support Workers and four residents.

The inspector also made observations of residents and staff interactions, interviewed residents and staff, reviewed residents clinical records, complaints, policies and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system put in place was complied with.

Review of the home's policy #A09-AD-013-11 "Prevention and Reporting of Resident Abuse/Neglect" revealed that "Registered Staff is to assess resident: provide first aid if required, complete head to toe assessment, take pictures (if applicable), contact the residents Power of Attorney, determine if 1:1 nursing care is required, assess if resident needs to be sent to hospital" and "Registered Staff to determine if or what type of referral needs to be initiated in order to support the resident", and "Family will be notified of any alleged abuse or neglect", and "Registered Staff to monitor resident for the next 24 hours with regular check-ins, to document on PCC progress notes and to address any needs of the resident".

An interview with resident #005, on a specific date, revealed that a "Resident & Family Concern" form was submitted to the Administrator on a specific date, regarding an alleged abuse.

A review of the "Resident & Family Concern" form revealed that an incident occurred between resident #002 and resident #003 on a specific date. Resident #004 witnessed the incident and stated that a staff came and made a report.

Review of the Administrator's follow-up on a specific date revealed that the Administrator attempted an interview with resident #003 who denied that the incident occurred and resident #004 confirmed witnessing the incident. The report indicated "No further action at this time".

A clinical record review of resident #003's progress notes revealed no documented evidence of the incident. There was no evidence to support that the resident was assessed after the incident and that the Power of Attorney was contacted.

The Administrator and Acting DOC/RAI Coordinator confirmed that the home's policy "Prevention and Reporting of Resident Abuse/Neglect" was not complied with. [s. 8. (1) (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 to ensure that any plan, policy, protocol, procedure, strategy or system put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported was immediately investigated.

An interview with resident #005, on a specific date, revealed that a "Resident & Family Concern" form was submitted to the Administrator on a specific date, regarding an alleged abuse.

A review of the "Resident & Family Concern" form revealed that an incident occurred between resident #002 and resident #003 on a specific date. Resident #004 witnessed the incident and stated that a staff came and made a report.

Review of the Administrator's follow-up on a specific date revealed that the Administrator attempted an interview with resident #003 who denied that the incident occurred and resident #004 confirmed witnessing the incident. The report indicated "No further action at this time".

An interview with the Administrator and Acting Director of Care/RAI Coordinator, who was unaware of the incident, shared that the incident was abuse and that the expectation of the home was that the incident should have been thoroughly investigated by the home and reported to the Director. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #3: 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

An interview with resident #005, on a specific date, revealed that a "Resident & Family Concern" form was submitted to the Administrator on a specific date, regarding an alleged abuse.

A review of the "Resident & Family Concern" form revealed that an incident occurred between resident #002 and resident #003 on a specific date. Resident #004 witnessed the incident and stated that a staff came and made a report.

Review of the Administrator's follow-up on a specific date revealed that the Administrator attempted an interview with resident #003 who denied that the incident occurred and resident #004 confirmed witnessing the incident. The report indicated "No further action at this time".

A clinical record review of residents #001 and #002 revealed no evidence that the alleged abuse was documented or reported by the staff members.

An interview with the Administrator and Acting Director of Care/RAI Coordinator, who was unaware of the incident, confirmed that this incident was abuse and that the expectation of the home was that the incident should have been reported to the Director. [s. 24. (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 a person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

On separate dates, four complaints were submitted by residents to the Ministry of Health and Long Term Care regarding residents wandering into other residents' rooms. The complaints also indicated the residents that were wandering presented an increase in behaviours.

A review of the home's "Resident & Family Concern" forms from the home’s concerns and complaints binder, during a specified time frame, revealed 12 resident complaints of residents wandering into their rooms.

A review of the complaints revealed that residents were wandering into other residents' rooms by removing the wanderguards and these residents were removing resident's personal objects from their rooms. The complaints indicated that these behaviours were increasing over time. The complainants were requesting “better way/solutions” to deal with these behaviours other than wanderguards.

An interview with the complainants on a specific date, confirmed that residents wandering presented an increase in behaviours and that home's current interventions has not been effective and did not feel supported by the home.

An interview with the Administrator on a specific date confirmed that she received many complaints about wanderers in the past few months and that it has been hard to deal with it.

An interview with the Acting Director of Care/RAI Coordinator/BSO confirmed that some residents are wandering and going into other residents’ room, that resident #001 and #002 have had increasing responsive behaviours including physical agression in the past few months.

The Acting Director of Care/RAI Coordinator/BSO confirmed that the two residents have not had a recent BSO assessment or any other assessment related to their responsive behaviours and that other solutions, like baby gates and motor sensor, for preventing wandering residents to enter residents room have been discussed but not implemented. [s. 54. (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 to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

Issued on this 15th day of March, 2016

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

Original report signed by the inspector.