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 prévue 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 soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 21, 2019	2019_508137_0025	032175-18, 032658-18, 005260-19	Complaint

Licensee/Titulaire de permis

Corporation of the County of Huron
77722A London Rd R. R. #5 CLINTON ON N7A 1M2

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

MARIAN MACDONALD (137)

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 17020, 2019

The following inspections were conducted concurrently during this Complaint inspection:

Follow Up to Compliance Order #001 and Log #000852-19 related to Duty to Protect;
Critical Incident System (CIS) report M601-000001-19 and Log #000756-19 related to alleged improper/incompetent care to a resident;
CIS report M601-000006-19 and Log #003650-19 related to Infection Prevention and Control;
CIS report M601-000010-18 and Log #032175-18 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, Program Manager, Business Manager, Environmental Services Manager, Resident Care Administrative Assistant, Social Worker, Registered Nurses and Personal Support Workers.

The inspector also toured the home, observed resident care provision, staff to resident interactions, availability of fall prevention equipment, reviewed resident clinical records, infection prevention and control practices, investigative notes and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 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. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to concerns regarding falls prevention and management for an identified resident.

A review of the plan of care showed a fall prevention device was to be applied when the identified resident was in bed. The resident sustained a fall resulting in injury and transfer to hospital for assessment. The progress notes contained documented evidence that the fall prevention device was not applied prior to the incident.

During an interview, a Registered Nurse (RN) said the fall prevention device should have been applied as per the care plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to an identified resident, specifically related to the use of fall prevention device when the resident was in bed. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 5th day of July, 2019

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

Original report signed by the inspector.