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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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 24, 2020	2020_796754_0024	003444-20	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Huron
1 Courthouse Square GODERICH 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

TAWNIE URBANSKI (754)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 18-20, 2020.

**The following intakes were completed during this critical incident inspection:
Log #003444-20, related to falls prevention management.**

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurse (RN), and Personal Support Worker (PSW).

The inspector made observations of resident care, and resident/staff interactions. A record review of the plan of care of the identified residents was completed. The home's relevant policies and procedures and related documentation was also reviewed.

**The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Skin and Wound Care**

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

- **2 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 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #001 exhibited altered skin integrity upon return from hospital they were assessed by a member of the registered nursing staff.

A Critical Incident Report was submitted to the Ministry of Long Term Care which documented that resident #001 had altered skin integrity requiring transfer to hospital.

There was no documented assessment of the area of altered skin integrity when the resident returned from hospital.

RN #101 said they could not find any skin assessments for resident #001 when they were transferred to hospital for altered skin integrity.

Director of Care (DOC) #100 said they would expect that a skin assessment would be completed for a resident returning from hospital with altered skin integrity and they acknowledged that an assessment was not completed for resident #001.

The licensee failed to ensure that when resident #001 exhibited altered skin integrity upon return from hospital they were assessed by a member of the registered nursing staff. [s. 50. (2) (a) (ii)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to inform the director within three business days after the occurrence of resident #001's injury where they were transferred to hospital and returned to the home with a significant change in status.

A Critical Incident (CI) report was submitted to the Ministry of Long Term Care which documented that resident #001 received an injury in early February 2020, and had to be transferred to hospital.

Documentation showed resident #001 returned from hospital the same day and changes were made to their care plan. Resident #001 had a significant change in status upon their return from hospital.

PSW #103 said that resident #001 had a significant change in their status.

DOC #100 said they were unsure why the CI report was submitted late February 2020, and not sooner.

The licensee failed to inform the director within three business days after the occurrence of resident #001's fall where they were transferred to hospital and returned to the home with a significant change in status. [s. 107. (3.1) (b)]

Issued on this 25th day of August, 2020

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

Original report signed by the inspector.