



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des Soins
de longue durée**

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

**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**

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 24, 2018	2018_674610_0026	024147-17, 027806- 17, 002368-18, 020607-18	Critical Incident System

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

Huronview Home for the Aged
R. R. #5, Lot 50, Con 1, Municipality of Huron East CLINTON ON N0M 1L0

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

NATALIE MORONEY (610)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des Soins
de longue durée**

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

**Rapport d'inspection prévue
sous *la Loi de 2007 sur les foyers
de soins de longue durée***

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

This inspection was conducted on the following date(s): December 18, 2018

The following critical incident were completed concurrently during this inspection:

SAC report #18406/ M541-000001-18, Log #020607-18, related to responsive behaviours.

CIS #M541-000010-17, Log #024147-17, related to a fall with injury that resulted in a transfer to hospital.

CIS #M541-000014-17, Log #027806-17, related to a fall with injury that resulted in a transfer to hospital.

CIS #M541-000008-18, Log #020607-18, related to a fall with injury that resulted in a transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Registered Nurses, and Personal Support Workers.

Inspector(s) also reviewed relevant policy and procedures, record documentation, and observed resident care areas and resident care.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Responsive Behaviours

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

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: 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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person was taken to hospital. O. Reg. 79/10, s. 107 (3).

The Ministry of Health and Long Term Care (MOHLTC) received three Critical Incident Report (CIS) submitted by the home related to falls with injury that had resulted in a transfer to the hospital for three identified residents.

A review of record documentation for three identified residents showed that the home was aware of each resident's injury for the three identified residents that were taken to hospital and the occurrences of the incidents had not been reported to the Director.

Interview with the DOC stated that the home's expectation was that they were to report to the MOHLTC within one business for injury that resulted in a transfer to hospital and had failed to do so for the identified residents.



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des Soins
de longue durée**

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

**Rapport d'inspection prévue
sous *la Loi de 2007 sur les foyers
de soins de longue durée***

Issued on this 14th day of January, 2019

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

Original report signed by the inspector.