Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
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Original Public Report

Report Issue Date: May 8, 2023
Inspection Number: 2023-1560-0004
Inspection Type: Follow up Critical Incident System
Licensee: Corporation of the County of Huron
Long Term Care Home and City: Huronview Home for the Aged, Clinton

Lead Inspector	**Inspector Digital Signature**
Debbie Warpula (577)	Debbie L Warpula Digitally signed by Debbie L Warpula Date: 2023.05.10 15:37:50 -04'00'

Additional Inspector(s)
Rhonda Kukoly (213)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2 and 3, 2023

The following intake(s) were inspected:

- Intake: #00086139 - Fall of a resident resulting in injury; and
- Intake: #00020848 - Follow-up #: 1 – Compliance Order CO #001 from Inspection #2023_1560_0003 related to FLTCA, 2021, s. 3 (1) 16

The following intakes were completed in this inspection: intake #00022226; intake #00022296; and intake #00019552, related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1560-0003 related to FLTCA, 2021, s. 3 (1) 16. inspected by Debbie Warpula (577)

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed related to their mobility device, a specific device and a care activity.

Rationale and Summary
A Critical Incident was reported to the Ministry of Long-Term Care (MLTC), whereby a resident had a fall resulting in an injury and required medical treatment. On readmission to the home, they were assessed as requiring specific assistance with a care activity. In the following days, the resident required the use of a specific mobility device and the resident required a specified level of assistance with a particular

care activity. The resident was observed during the inspection, to be in a particular position in a mobility device with a specific device. There was no reassessment related to the care activity, mobility device or specific device, when they were implemented; and the care plan, kardex, tasks and logo in the resident room did not indicate any of these interventions.

A Registered Nurse (RN) stated the particular position in the mobility device with a specific device should not have been used until an assessment was completed to determine if the device was a Personal Assistive Service Device (PASD) or a restraint, consent and order obtained, and included in the plan of care, kardex, tasks and logo in place. They also said there should have been a specific referral and assessment completed if the resident was requiring a device more often for a care activity, with the care plan, kardex, and logo updated, along with the recommended size. There was risk that the resident didn't receive the required care when they were not reassessed and the care plan revised when their mobility needs changed.

After discussion with the RN, they had all of the appropriate assessments completed and the care plan, kardex, tasks and logos were updated immediately.

Sources: a Critical incident report, health records for a resident and staff interviews. [213]

Date Remedy Implemented: May 3, 2023

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care related to a particular device, was provided to a resident, as specified in the plan.

Rationale and Summary
A Critical Incident was reported to the MLTC, whereby a resident had a fall resulting in an injury. At the time of the fall, the resident had been assessed as a particular risk for falls and a specific device was included in the resident's plan of care, as a prevention intervention. When the resident was found to have fallen, staff found that the falls prevention device in place was not functioning and therefore could not act as a fall prevention device.

Sources: a Critical incident report, health records for a resident, and staff interviews. [213]