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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Dec 8, 2015	2015_216144_0065	032440-15	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE CITY OF WINDSOR
1881 Cabana Road West WINDSOR ON N9G 1C7

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

HURON LODGE LONG TERM CARE HOME
1881 CABANA ROAD WEST WINDSOR ON N9G 1C7

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

CAROLEE MILLINER (144), ALISON FALKINGHAM (518), SANDRA FYSH (190)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 30, December 1, 2, 3, 4, 7, 2015

During the course of the inspection, the inspector(s) spoke with 40+ residents, three family members, the Administrator, Director of Care (DOC), Director of Resident Services, Coordinator of Dietary Services and Nutrition Supervisor, the Registered Dietitian (RD), Food Service Manager, Environmental Services Manager, six Registered Nurses (RN), five Registered Practical Nurses (RPN), eight Personal Support Workers (PSW), one Health Care Aide (HCA) and one Dietary Aide(DA).

During the course of the inspection, the Inspector(s) toured all resident home areas, medication rooms, observed dining service, medication administration, provision of care, recreational activities, resident/staff interactions, infection prevention and control practices, reviewed residents clinical records, posting of required information, meeting minutes related to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

2 WN(s)
2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provided direct care to the resident.

A) One identified resident was observed propelling their wheelchair with a seat belt in place.
B) The resident was able to undo and refasten the seat belt when asked to do so by the Inspector.
C) On review of the resident's current plan of care, it was noted that the seat belt was not included.
C) Interviews with two Personal Support Workers (PSW's) and one registered staff member revealed that the resident requested a seat belt The PSW's and registered staff also stated that they would expect the seat belt to be included in the resident's plan of care.
D) The DON confirmed the resident's plan of care did not provide clear direction to staff and it was her expectation that the resident's seat belt would be documented in the plan of care. [s. 6. (1) (c)]

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 plan of care sets out clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident with a change of five per cent of body weight, or more, over a one month period was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

A) The clinical record for one resident revealed a documented weight discrepancy between two months in 2015.
B) The Registered Dietitian (RD) confirmed the home's electronic software program for the nursing department alerted her to the discrepancy between the weights, and that she asked an RPN to ensure the resident was re-weighed. The RD advised that after the request for the re-weigh, she did not complete further follow-up with the resident and did not assess them.
C) One RPN confirmed the discussion with the RD related to re-weighing the resident and stated she had asked Personal Support Workers (PSWs) to complete the re-weigh however, was not able to recall which staff were asked.
D) One RN, one RPN and one PSW were not able to provide evidence to substantiate that the resident was re-weighed in response to the weight discrepancy and concurred that the re-weigh did not occur and that the resident was not assessed.
E) The resident's clinical record revealed the resident was not weighed for another month.
F) The Administrator and Coordinator of Dietary Services and Nutrition Management confirmed it was their expectation that the resident would have been immediately re-weighed in response to the weight discrepancy and an assessment completed as necessary. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 resident with a change of five per cent of body weight, or more, over a one month period is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

Issued on this 22nd day of December, 2015

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

Original report signed by the inspector.