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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 19, 2018	2018_532590_0007	005665-18	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

ALICIA MARLATT (590), CASSANDRA ALEKSIC (689), DEBRA CHURCHER (670), HELENE DESABRAIS (615), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 17 - 20, 23, 25 - 27, 30 and May 1 - 4, 2018.

The following intakes were inspected concurrently within this RQI:

Complaint inspection: Log #001006-18/IL-54996-LO was related to prevention of abuse and neglect;
Complaint inspection: Log #000911-18/IL-54970-LO was related to care conference

concerns;
Critical Incident System (CIS) inspection: Log #027917-17/CIS #M631-000019-17 was related to medication management;
CIS inspection: Log #007817-16/CIS #M631-000005-16 was related to prevention of abuse and neglect;
CIS inspection: Log #027680-17/CIS #M631-000018-17 was related to medication management;
CIS inspection: Log #023312-16/CIS #M631-000016-16 was related to falls prevention and management;
CIS inspection: Log #029108-17/CIS #M631-000021-17 was related to falls prevention and management;
CIS inspection: Log #001238-18/CIS #M631-000004-18 was related to falls prevention and management;
CIS inspection: Log #015241-17/CIS #M631-000011-17 was related to falls prevention and management;
CIS inspection: Log #032392-16/CIS #M631-000021-16 was related to falls prevention and management;
CIS inspection: Log #018971-16/CIS #M631-000002-16 was related to falls prevention and management;
CIS inspection: Log #016505-16/CIS #M631-000012-16 was related to prevention of abuse and neglect;
CIS inspection: Log #018586-16/CIS #M631-000013-16 was related to prevention of abuse and neglect;
CIS inspection: Log #020853-16/CIS #M631-000014-16 was related to falls prevention and management;
CIS inspection: Log #010803-16/CIS #M631-000007-16 was related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, two Assistant Director's of Care, the Environmental Services Supervisor, the Supervisor of Facilities and Maintenance, the Supervisor of Nutrition and Manager of Dietary Services, the Manager of Resident Services, one Pharmacist, the Activities Coordinator, one Social Worker, one Dietary Aid, the representative for the Residents' Council, the representative for the Family's Council, nine Registered Nurses (RN), six Registered Practical Nurses (RPN), 11 Personal Support Workers, six family members and 11 residents.

During the course of the inspection, the inspector(s) observed all resident home

areas, general cleanliness and maintenance of the home, dining and snack services, medication administration practices, medication storage areas, recreational activities, infection prevention and control practices, the provision of resident care, staff and resident interactions and the posting of required information.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, Infoline reports, Critical Incident System reports, Medication Incident reports, Family Council meeting minutes, Residents' Council meeting minutes, email correspondence, Professional Advisory Committee meeting minutes and policies and procedures relevant to inspection topics.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
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
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

During stage one of the Resident Quality Inspection (RQI), resident #003 stated that a staff member had been rude and the resident further reported that the staff member was "brusque". Resident #003 said they reported the incident to the Social Worker (SW) and had indicated that they did not want that particular staff member to provide care to them.

Section 2(1) of Ontario Regulation 79/10 defines verbal abuse as "any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self worth made by anyone other than a resident."

A review of resident #003's clinical record revealed no documentation related to the incident.

In an interview with SW #105, they shared that resident #003 had told them about an incident of alleged verbal abuse towards them by a staff member, but that they could not recall the details. SW #105 stated that they had several interactions and conversations with the resident after the initial report but that the resident did not mention it again. They said that they did not see any red flags at the time this was reported and had used the Ministry of Health and Long-Term Care (MOHLTC) abuse decision trees to determine that no action was required.

The home's policy titled Abuse and Resident Safeguards, Zero Tolerance, Neglect, Reporting and Prevention, last reviewed on June 29, 2017, stated:
Verbal abuse means, a) Any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well being, dignity or self worth, that is made by anyone other than a resident.
The procedure says:
1. Immediate mandatory reporting of any form of abuse (alleged or actual) or neglect is to occur to a manager or after hours supervisor on call.
2. All Regulated Health Professionals are accountable to maintain standards and procedures as per applicable legislation.

In an interview with Executive Director (ED) #100, they stated that a follow up meeting

was conducted with resident #003, and that the resident said they were upset by the statements from the staff member that day. The ED further shared that this incident should have been followed up according to the home's abuse policy, and that the home was continuing an investigation and follow up with the staff member involved. [s. 20. (1)]

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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) Review of the home's medication incident reports for a three month time period, showed a medication incident report on a specified date, related to resident #019 receiving the incorrect dose of a medication.

Review of resident #019's clinical record showed that resident #019 returned from a hospitalization and had readmission orders to start a specific dose of a prescribed medication. A physicians order from four days after readmission stated there was a clarification of orders for a specific dose of a prescribed medication for ten days, to end on a specified date. A progress note dated one day after the clarification, stated that RN #129 observed that the medication did not appear to be the correct medication. RN #129

then contacted the pharmacy and it was determined that the resident had received the wrong dose of medication.

The Physician was notified and the resident was subsequently sent to the emergency room for assessment and returned to the home on the same day with no change in condition.

B) Review of the home's medication incident reports showed a medication incident which occurred on a specific date, related to resident #020 receiving the incorrect dose of a medication.

Review of resident #020's clinical record showed that the resident had an order for one tablet of a specified medication. When the order reached the pharmacy there was a transcription error changing the dose. The resident received the wrong dose of a medication on a specified date.

The resident was monitored and no adverse effects were noted.

C) Review of the home's medication incidents showed a medication incident which occurred on a specific date, related to resident #021 receiving the incorrect dose of a medication.

Review of resident #021's clinical record showed that on a specific date, the physician had discontinued an order for a specified medication and had written a new order for the same medication with new directions. Review of the medication incident report, resident #021's progress notes and medication record, showed that RPN #131 had administered the previously ordered dose of medication to resident #021 on the identified date.

The resident was monitored for adverse effects with none noted.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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 directions to staff and others who provided direct care to the resident.

During stage one of the RQI resident #006 was observed to be utilizing a positioning device for comfort.

Resident #006's current care plan documented that the resident walked with a walker. There was no mention that the resident used a positioning device for any purposes.

In an interview with RN #106, they shared that the resident's current ambulation status should be updated in the care plan and on the kardex for all staff providing care. The RN said that resident #006 had been using the positioning device for approximately three months now and it should be in their care plan.

In an interview with ADOC #105 they also shared that resident #006 had been using the positioning device for a few months now and that the care plan should have been up to date to reflect that the resident used this device. [s. 6. (1) (c)]

Issued on this 19th day of June, 2018

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

Original report signed by the inspector.