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

London Service Area Office
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London ON N6A 5R2
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Original Public Report

Report Issue Date November 24, 2022
Inspection Number 2022_1626_0003
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Corporation of the City of Windsor

Long-Term Care Home and City
Huron Lodge Long Term Care Home
Windsor

Lead Inspector
Jennifer Bertolin(740915)

Additional Inspector(s)
Cassandra Taylor (725)
Julie D'Alessandro (739)

Choose an item.

Jennifer Bertolin
Digitally signed by Jennifer Bertolin
Date: 2022.11.25 13:19:35 -05'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s):
November 7th-10th, 2022 and November 14th-16th, 2022

The following intake(s) were inspected:

- Intake: #00001893-(Complaint)- related to medication management.
- Intake: #00002492-(CIS)- [CI: M631-000007-22] related to falls prevention and management.
- Intake: #00005259-(CIS)- [CI: M631-000014-22] related to falls prevention and management.
- Intake: #00007269-(CIS)- [CI: M631-000006-22] related to falls prevention and management.
- Intake: #00009084-(CIS)- [CI: M631-000015-22] related to falls prevention and management.

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

- Falls Prevention and Management

- Infection Prevention and Control (IPAC)
- Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION#001: DUTY OF LICENSEE TO COMPLY WITH PLAN

NC#001 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 a resident was transferred as per their plan of care.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care indicating that a resident had a fall and sustained an injury. The resident was admitted to the hospital for surgery. The resident was readmitted to the home with limited functions.

A record review was completed and found that the fall was a result of a staff member not transferring the resident as per their care plan. The Post Fall Investigation document, completed by registered staff, stated in the Summary and Plan section the care plan was not followed appropriately.

Review of the care plan indicated the transfer status of the resident was a two person assist with the use of an assistive device. Interview with the staff member confirmed they transferred the resident independently. During the interview with the staff member, it was confirmed that they knew where to locate the plan of care in the resident's room to confirm transfer status and did not reference it prior to transfer. The staff member stated in their interview that the resident was a one person transfer at the time of the fall. The Inspector confirmed with management that at the time of fall the resident's transfer status was a two person assist with the use of an assistive device.

Sources: Resident's records; Post Fall Investigation document: Interview with staff members and management

[740915]

WRITTEN NOTIFICATION#002: TRANSFERRING AND POSITIONING TECHNIQUES

NC#002Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O.Reg. 246/22, s. 40

The licensee was required to ensure that proper and safe transferring techniques were utilized post fall.

Rationale and Summary

A resident had a fall and sustained an injury. During an interview a staff member stated they transferred the resident with a co-worker by hooking their arms under the resident's axilla and holding the back of the resident's pants to lift them from the floor to the wheelchair.

The home's Fall Prevention and Management Program Policy stated that a resident should have a head-to-toe assessment completed by registered staff prior to transfer, and the home's Home Procedure Policy, stated a passive lift was to be utilized to transfer a resident off the floor.
Staff member indicated they were aware that registered staff were to complete a head-to-toe assessment prior to moving the resident off the floor but stated they did not inform registered staff about the fall until after the resident was transferred into a wheelchair and brought to the nursing station.
A review of the resident's progress notes indicated that registered staff were not aware of the fall and that the staff member and their co-worker did not use a passive lift to transfer the resident off the floor.

Sources: Resident's records; Interview with staff member; Home's Fall Prevention & Management Program Policy and Home Procedure Policy

WRITTEN NOTIFICATION#003: REQUIRED PROGRAMS

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O.Reg. 246/22, s. 53 (1) 4.

The licensee failed to ensure that the pain management policy was complied with for a resident when they returned from hospital after a fall with a fracture.

In accordance with O. Reg 246/22 s. 53. (1) the licensee is required to ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain.

In accordance with O. Reg 246/22 s. 11. (1) where the licensee is required to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.
Rational and Summary

A resident was identified as having had a fall and sustained an injury which required hospitalization. The resident's treatment plan was to return to the Long-Term Care home with a device to support healing. The resident was readmitted to the home with a significant change in condition and no pain assessment was completed.

The home's Pain Management policy stated in part that, "each resident must have a formal pain assessment on admission and be reassessed on readmission, quarterly and at significant condition changes. Staff are to complete a pain assessment utilizing a clinically appropriate instrument (pain custom e-assessment in Med e-Care), within 24 hours of admission, quarterly (according to the RAI-MDS 2.0 schedule), when a resident exhibits a change in health status or pain is not relieved by initial interventions."

During an interview with the management, they acknowledged that an assessment should have been completed.

Sources: Resident's records, the home's Pain Management Policy and interview with management

WRITTEN NOTIFICATION#004: PAIN MANAGEMENT PROGRAM

NC#004Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O.Reg. 246/22, s. 57 (2)

The licensee failed to ensure that when a resident's pain was not relieved by the initial interventions, that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rational and Summary

A resident was identified as having a fall and sustained an injury. The resident was readmitted to the home and continued with their regular scheduled pain management routine that included breakthrough doses of pain medication. After a bit of time, staff began documenting that the breakthrough dose of certain type of pain medication was not effective at times and placed the resident on the list for Physician rounds. The physician ordered a change in the pain management routine and to continue with the breakthrough pain medication. During this time an assessment designed to assess pain was not completed.

Review of the home's policy stated in part; that staff are to complete a pain assessment utilizing a clinically appropriate instrument (pain custom e-assessment in Med e-Care), within 24 hours of admission, quarterly (according to the RAI-MDS 2.0 schedule), when a resident exhibits a change in health status or pain is not relieved by initial interventions.

During an interview with management they indicated that a pain assessment should have been

completed and staff should follow the policy.
Sources: Resident's records, the home's Pain Management policy and interview with management. [725]

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.

- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.