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
Feb 19, 2016	2016_355588_0003	031527-15	Complaint

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF HURON
c/o Huronlea HFA 820 Turnberry Street South BRUSSELS ON N0G 1H0

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

HURONLEA HOME FOR THE AGED
820 TURNBERRY STREET SOUTH BRUSSELS ON N0G 1H0

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

CHRISTINE MCCARTHY (588)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 19, 20, 2016

This inspection was completed concurrently with Log #024568-15.

During the course of the inspection, the inspector(s) spoke with the Complainant, Administrator, Assistant Director of Care/Resident Assessment Instrument Coordinator/ Behaviour Supports Ontario (ADOC/RAI-C/BSO), Charge Nurse, Registered Practical Nurse, and three Personal Support Workers

The following Inspection Protocols were used during this inspection:
Pain

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	
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 directions to staff and others who provide direct care to the resident.

Telephone interview with the Complainant and family member of the deceased resident revealed concerns related to the care of their palliative family member. The Complainant revealed that the deceased resident was provided thickened fluids at a time when they were not able to manage them.

Interview with a Registered staff revealed that the process of palliative care was defined in terms of the residents’ ability to take food and fluids at any given time, and that the fluid intake would be communicated on Point of Care (POC) and during shift report.

Record review of the Care Plan Update revealed “Now Palliative, Refer to Home Medical Directives (Palliative & Oxygen) for pain & symptom management”.

Record review of the Care Plan Detail revealed “death is expected” as per the physician and that the resident was to remain at the Home with palliative support until time of death.

Record review of the most recent Plan of Care in Point Click Care revealed the Dietary Care Plan to include: “To provide supportive/comfort measures with food and fluid as tolerated/appropriate for hunger or thirst during end stages of life.”

Record review of the Policy #A09-PS-214-10 Nutrition and Palliative Care - "Residents who are palliative will have nutrition care based on his/her needs which supports resident comfort, dignity and quality of life. As optimum nutrition is no longer feasible, the focus will be on resident requests, while attempting to maintain hydration and prevent hunger related nausea. -offering a variety of fluids, including supplements and ice chips, to satisfy hunger and thirst; never pushing the resident to eat or drink."

Record review of the most recent Kardex in Point Click Care revealed the “Diet” to include: “Provide Regular diet”.

Interview with the Administrator confirmed that the Kardex was not updated to reflect the change in status of the resident, and did not provide clear direction to the staff, and that the homes' expectation was to have the Kardex updated so as to provide clear direction to staff. [s. 6. (1) (c)]

Issued on this 19th day of February, 2016

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

Original report signed by the inspector.