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_0002	024568-15	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 conducted concurrently alongside Log #031527-15.

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, one Registered Nurse, one Registered Practical Nurse, and two Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Reporting and Complaints

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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home be investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

Telephone interview with the Complainant and family member of the deceased resident revealed that a family member sent an extensive email describing many issues and concerns to Staff #100, and to which they never received a response.

Interview with Staff #100 revealed that the Director of Care(DOC) would have been the person most likely to receive any such correspondence from the family member. Staff #100 felt that the DOC may have had a verbal conversation with the family member instead of responding in an email. The DOC was unavailable to interview.

Interview with the Administrator revealed that in reviewing their emails, they were not able to locate correspondence or an identified email from the family member during the specific time-frame described.

Record review of the email supplied by the Complainant, revealed that the email was sent to Staff #100 on a specified date and that the email described multiple issues and frustrations.

Record review of the Plan of Care in Point Click Care revealed an absence of documentation related to receipt of the complaint or any email correspondence relating to the complaint.

Interview with the Assistant Director of Care/Resident Assessment Instrument Coordinator/Behaviour Supports Ontario (ADOC/RAI Coordinator/BSO) confirmed the accuracy of the email address for Staff #100 to whom the email was addressed. At that time, the ADOC/RAI Coordinator/BSO shared that they were not able to find any reference to the email in any of the folders on Staff #100's email.

Interview with Staff #100 revealed that they thought that the email was sent to the DOC and that they did not recall writing back to the family member. Staff #100 shared that the homes' process was to forward all complaints to the DOC, and that they did not know what happened after this point in time.

Interview with the ADOC/RAI Coordinator/ BSO revealed that Staff #100, to whom the email was addressed, was not present in the home during the identified time-frame, due to an absence. The ADOC/RAI Coordinator/ BSO revealed that upon reflection, Staff #100 shared that they may have opened the email upon return from their work absence and by that time, the resident was deceased. The ADOC/RAI Coordinator/ BSO shared that Staff #100 did not respond to the family or forward the email to the DOC, due to the fact that the resident had passed away. The ADOC/RAI Coordinator/ BSO confirmed that it was the homes' expectation to respond to the concern or complaint within a 10 day period and this did not occur in this instance. [s. 101. (1) 1.]

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.