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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2018	2018_735659_0022	021229-18	Complaint

Licensee/Titulaire de permis

Corporation of the County of Huron
77722A London Rd R. R. #5 CLINTON ON N7A 1M2

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

JANETM EVANS (659)

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): October 29, 30, 31, November 1, 5, 6, 7 and 8, 2018.

The following intake was included with this inspection:
Log #021229-18\IL-59003-CW/IL-59429-CW related to alleged verbal abuse and administration of medication.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 24.(1), identified in a concurrent inspection #2018_735659_0021 (Log # 031267-18\ CIS#M601-000008-18) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Business Manager, Resident Care Administrative Assistance, Police, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers, Recreation staff and residents.

The inspector (s) also made observations related to mandatory postings, provision of care, staff to resident interactions and a medication pass and reviewed clinical records, staffing records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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	Légende 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Two complaint intakes were received in a specified month which alleged an identified resident had not received appropriate care related to medication administration and there were inappropriate interactions from the staff toward the resident.

A progress note indicated on a specified date that the identified resident was upset about their medication administration. A Registered Practical Nurse (RPN) intervened and attempted to de-escalate the situation.

The Administrator reported that an Ontario Provincial Police (OPP) officer arrived at the home to complete an investigation of the home for alleged abuse and neglect of the identified resident by staff. The officer met with the Administrator and a charge nurse.

The Administrator acknowledged that they had not notified the Director of the allegation of abuse and neglect of the identified resident.

2. Review of the clinical record for an identified resident showed progress note documentation which indicated a Personal Support Worker (PSW) witnessed an identified resident exhibiting responsive behaviours towards another resident. Upon noticing the PSW, the resident stopped the behaviour.

The clinical record for the identified resident showed a history of prior responsive behaviours directed to both staff and residents.

The home's investigation was inconclusive as to what took place between the two residents..

A PSW stated that on a specified date they observed the identified resident exhibiting responsive behaviours towards a second resident. The second resident tried to stop the behaviour. The PSW separated the residents, took them to their rooms and they notified the nurse.

The Administrator acknowledged that they had not notified the Director of either incident.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. [s. 24. (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 person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 142. Care during absence

Every licensee of a long-term care home shall ensure that before a long-stay resident of the home leaves for a casual absence or a vacation absence and before a short-stay resident of the home leaves for a casual absence,

(a) a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff of the home sets out in writing the care required to be given to the resident during the absence; and

(b) a member of the licensee's staff communicates to the resident, or the resident's substitute decision-maker,

(i) the need to take all reasonable steps to ensure that the care required to be given to the resident is received by the resident during the absence,

(ii) that the licensee will not be responsible for the care, safety and well-being of the resident during the absence and that the resident or the resident's substitute decision-maker assumes full responsibility for the care, safety and well-being of the resident during the absence, and

(iii) the need to notify the Administrator of the home if the resident is admitted to a hospital during the absence or if the date of the resident's return changer. O. Reg. 79/10, s. 142.

Findings/Faits saillants :

1. The licensee has failed to ensure that before a long-stay resident of the home leaves for a casual absence or a vacation absence and before a short-stay resident of the home leaves for a casual absence, (a) a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff of the homes sets out in writing the care required to be given to the resident during the absence.

A complaint was received to the Ministry of Health and Long Term Care, which identified concerns related to a specified medication incident.

The progress notes for the identified resident showed they had requested sufficient medications for an absence from the home.. The documentation stated the medications were prepared and sent, including controlled substances cards being counted and verified by two registered staff. A required medication had not been documented on the form.

The complaint form stated that after leaving the home, the resident noted that they were missing one of their medications..

The RPN and RN stated that the identified resident had not been provided with sufficient medication their absence. The RPN and DOC acknowledged they had not documented one of the medications on Medication absence form.

The licensee had failed to ensure that before a long-stay resident of the home leaves for a casual absence or a vacation absence and before a short-stay resident of the home leaves for a casual absence, (a) a physician or a registered nurse I the extended class attending the resident or a member of the registered nursing staff of the homes sets out in writing the care required to be given to the resident during the absence. [s. 142. (a)]

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 before a long-stay resident of the home leaves for a casual absence or a vacation absence and before a short-stay resident of the home leaves for a casual absence, (a) a physician or a registered nurse in the extended class attending the resident or a member of the registered nursng staff of the homes set out in writing the care required to be given to the resident during the absence, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included: every date on which any response was provided to the complainant and a description of the response.

A complaint from a specified date that indicated that follow up had been completed. The follow up documented a summary of information from the progress notes, but it did not identify a description of the response provided to the complainant.

Additional complaints were provided to the Inspector in the form of a complaint summary. The complaint summary detailed six complaints for 2018. Review of the complaint summary detailed actions the home took, but there was no documented description of the response provided to the resident/family for each complaint.

The licensee had failed to ensure that a documented record was kept in the home that included: every date on which any response was provided to the complainant and a description of the response. [s. 101. (2)]

Issued on this 10th day of January, 2019

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

Original report signed by the inspector.