

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: September 22, 2023	
Inspection Number: 2023-1597-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: Corporation of the County of Huron	
Long Term Care Home and City: Huronlea Home for the Aged, Brussels	
Lead Inspector Helene Desabrais (615)	Inspector Digital Signature
Additional Inspector(s) Alicia Campbell (741126)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 12, 13, 15, 19, 20, 21, 2023

The following intake(s) were inspected:

- Intake: #00096180 - PCI – Huronlea

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Medication Management
- Food, Nutrition and Hydration
- Residents’ and Family Councils
- Safe and Secure Home
- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Quality Improvement
- Residents’ Rights and Choices
- Pain Management
- Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Continuous Quality Improvement

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 42

The licensee has failed to implement a continuous quality improvement initiative as provided for in the regulations.

Rational and Summary

The continuous quality improvement (CQI) initiative committee of the home was co-ordinated by the home's Director.

The Director stated that each department in the home completed their audits. There have been no CQI committee meetings to review reports from the various committees to assist with developing action plans and measures to improve the resident's safety and quality of service. The Director could only provide the last CQI committee minutes of December 2019, when the last meeting was held. No CQI plans were shared with the resident's council and was not on the home's website.

The Director stated that these meetings were not completed because of the pandemic and staffing challenges.

The Administrator of the home stated that the expectation was to have the CQI committee implemented.

Sources: Home's Resident Safety Quality Terms of Reference policy, CQI meeting minutes dated December 2019, interviews with the home's Director, the Administrator and the DOC.
[615]

WRITTEN NOTIFICATION: Maintenance services

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

Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee has failed to ensure that there were schedules and procedures in place for routine and preventive

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maintenance, specifically for the resident-staff communication and response system (RSCRS).

Rationale and Summary

The resident bathroom RSCRS in the home was activated by pulling on a cord that had a connection piece in the center. On September 12 and 13, 2023, the cords on eight of these systems were found to be breaking at the site of connection, which did not allow the system to be activated.

The Administrator stated that no physical audits had been completed to check the RSCRS.

When the RSCRS was not monitored and maintained to function as intended, resident safety was put at risk.

Sources: the home's Call Bell Response Policy dated September 18, 2023, observations and interviews with the Administrator and the ADOC.

[741126]