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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 12, 2014	2014_262523_0014	L-000333-14	Critical Incident System

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

ALI NASSER (523)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 5 & 7, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, Business Manager, Program & Social Services Coordinator, Registered Staff, Personal Support Worker and three Residents

During the course of the inspection, the inspector(s) reviewed critical incident report, clinical records, plan of care, internal investigation reports, policies and procedures, meeting minutes, observed Resident care areas and staff-Resident interaction,

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

Findings of Non-Compliance were found during this inspection.

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that staff complied with the Home's Policy on Prevention and Reporting of Resident Abuse/ Neglect, Policy # A09-AD-013-11, which states on page 5 of 5 under the Evaluation and Review of Abuse Program that :
The Abuse program will be reviewed annually by Residents Council and Family Council (if one exists). Any identified improvements will be implemented.
This was evidenced by:
A review of the Residents Council minutes from January 2013 to date revealed that discussions on reviewing or evaluating the Abuse program did not occur.
This was confirmed in an interview with Program & Social Services Coordinator [s. 8. (1) (a)]

2. The Licensee has failed to ensure that staff complied with the Home's Policy on Prevention and Reporting of Resident Abuse/ Neglect, Policy # A09-AD-013-11, which states in section one of the Procedure that :
If an employee witnesses or suspects another employee, a family member or substitute decision maker, a visitor, a volunteer, another resident or any other person in the home, is abusing or neglecting a resident in any manner, the staff member should intervene to stop the abusive behavior, if this can be done with personal safety. If employee believes that intervention can not be achieved with personal safety, the employee should seek assistance immediately to stop the abuse, call Code white or call 911. The incident should be reported immediately to the Registered Nurse and /or Director of Care.
This was evidenced by:
The employee failed to stop another employee who was involved in the incident of alleged abuse involving resident #001 & #002.
The employee failed to immediately report the incident to the Director of Care, the report was made on March 11, 2014 , 3 days after the incident had occurred. [s. 8. (1) (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 ensuring the Home's policy "Prevention and Reporting of Resident Abuse/ Neglect, Policy # A09-AD-013-11" be complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the Resident's SDM and any other person specified by the Resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident . This was evidenced by:
The licensee was made aware of the incident on March 11, 2014 and it was reported to the Director on March 11, 2014 at 16:31 hours.
a) A review of Resident #001 clinical record revealed that the family were notified about the incident on May 1, 2014, 51 days after the home was made aware of the incident.
b) A review of Resident #002 clinical record revealed that the SDM or family were not notified of the incident to date.
This was confirmed by the Director of Resident Care.
In an interview with the Administrator and the Director of Resident Care it was confirmed that the Home's expectation is to notify the SDM or Family immediately in similar events. [s. 97. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The Licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.
In an interview with the Administrator and the Director of Resident Care it was confirmed that the police were not called about the allegation of abuse.
The Administrator and the Director of Resident Care confirmed that the Home's expectation is to call the police department whenever there is any alleged, suspected or witnessed abuse that may constitute a criminal offence. [s. 98.]

Issued on this 12th day of May, 2014

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

ALI NASSER