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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 6, 2015 | 2015_264609_0024 | 005714-15 | Complaint |

### Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF HURON
77722A London Rd R R 5 CLINTON ON N0M 1L0

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

HURONVIEW HOME FOR THE AGED
R. R. #5, LOT 50, CON 1 MUNICIPALITY OF HURON EAST CLINTON ON N0M 1L0

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

CHAD CAMPS (609)

### 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): April 23, 2015**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Administrator, one RAI (Resident Assessment Instrument) Coordinator, 2 Registered Nurses (RN), one Behavioural Supports Ontario (BSO) Staff Member and two Resident Family Members.**

**The inspector(s) also reviewed progress notes, plans of care, incident forms, policies and procedures and correspondence between the home and family members.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Falls Prevention**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted by the home is complied with.

In an interview with the DOC the home's policy titled "Falls Prevention and Management Program" revision date April 2011 was reviewed. The DOC confirmed the policy indicated that for all un-witnessed falls the staff are to initiate a Head Injury Routine (HIR) as a precautionary measure.

Progress and risk management notes for six falls involving three residents were reviewed. Of the six un-witnessed falls reviewed 50% did not have a HIR initiated. Record review and interview with the RAI Coordinator confirmed that a HIR was not initiated for each of these falls.

The DOC confirmed that it is the home's expectation that a HIR is to be started on all un-witnessed falls and in the case of the three cited falls this did not occur. [s. 8. (1) (b)]

***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 any plan, policy, protocol, procedure, strategy or system instituted by the home is complied with, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**
**i. a breakdown or failure of the security system,**
**ii. a breakdown of major equipment or a system in the home,**
**iii. a loss of essential services, or**
**iv. flooding.**
**O. Reg. 79/10, s. 107 (3).**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director is informed no later than one business day after an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

A review of progress notes revealed an incident at a specified time to an identified resident that resulted in the resident being transferred to the hospital.

Record review revealed that the identified resident sustained injuries which resulted in the plan of care being updated with new interventions.

Review of the progress notes further revealed that the identified resident would require increased assistance in daily living.

An interview with the DOC revealed that the significant change in the condition of the identified resident was not reported to the Ministry. The criteria for reporting significant changes to residents was reviewed with the DOC and she acknowledged the requirements under the Regulation and in the case of the identified resident that this did not occur. [s. 107. (3)]

***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 Director is informed no later than one business day of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.***

**Issued on this 6th day of May, 2015**

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

**Original report signed by the inspector.**