Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection ..évue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
June 7, 2011	2011_105_9541_07Jun084620	L-000589 Critical Incident

Licensee/Titulaire
Corporation of County of Huron 77722 London Rd. R.R. 5 Clinton ON N0G1L0

Long-Term Care Home/Foyer de soins de longue durée
Huronview HFA R.R 5 Clinton ON N0G 1L0

Name of Inspector/Nom de l'inspecteur
June Osborn #105

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to resident care.

During the course of the inspection, the inspector spoke with the administrator, the director of care, and the registered nurse.

During the course of the inspection, the inspector observed the 2 residents involved, interviewed the administrator, the director of care, and the registered nurse, reviewed the medical records of both residents, and reviewed the process the home uses to report Mandatory Reports, and training with respect to this reporting.

The following Inspection Protocols were used during this inspection: Responsive Behaviours, Prevention of Abuse, Neglect and Retaliation, and Training and Orientation.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA , 2007, S.O. c. 8, s. 24(1)2.
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:
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.

Findings:
1. The incident occurred on April 9, 2011 and was reported via critical incident report April 12, 2011; as evidenced by the Critical Incident Report M541-000007-11 and also by interview with the administrator who stated, "The report was late".

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. c.8, s. 76(2)4.
Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
4. The duty under section 24 to make mandatory reports.

Findings:
1. Staff have not been trained before performing their responsibilities, related to the duty to make mandatory reports under section 24. This is evidenced by the director of care stating "there would have been a letter but I can't produce it" and further stated "it would have gone to the RNs". On interview with the registered nurse she shared that the incidents all are reported within 24 hours.

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Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: June 9, 2011