



**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

**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**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
May 20, 2014	2014_183135_0031	L-000396-14	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**

BONNIE MACDONALD (135)

**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): May 7, 2014.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Registered Nurse, 4 Personal Support Workers, 2 Health Care Aides and Resident.

During the course of the inspection, the inspector(s) reviewed resident clinical records and related policies and procedures. Observed resident care and services provided in resident home area.

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



**Findings of Non-Compliance were found during this inspection.**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<p>Legend</p> <p>WN – Written Notification            VPC – Voluntary Plan of Correction            DR – Director Referral            CO – Compliance Order            WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit            VPC – Plan de redressement volontaire            DR – Aiguillage au directeur            CO – Ordre de conformité            WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**



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

- s. 23. (1) Every licensee of a long-term care home shall ensure that,**
- (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
    - (i) abuse of a resident by anyone,**
    - (ii) neglect of a resident by the licensee or staff, or**
    - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
  - (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
  - (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**
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**Findings/Faits saillants :**

1. The Licensee failed to ensure that, every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
- (i) Abuse of a resident by anyone

Record review revealed two incidents of suspected abuse of Resident #01 were reported by staff to Registered staff:

Critical Incident worksheets were initiated by the Registered staff after each incident.

During interviews with staff they expressed concerns that there was suspected abuse of a resident.

In an interview with the Director of Care she verified that there was no record of an investigation or witness statements when abuse of a resident was suspected. [s. 23. (1) (a)]



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***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 that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.***

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**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).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident when the following occurred:

Staff reported suspected abuse of Resident #01.

Record review revealed the SDM was not notified within 12 hours of the home becoming aware of the suspected abuse of Resident #01.

In an interview with the Director of Care she verified that the SDM was not notified within 12 hours of the suspected abuse of Resident #01. [s. 97. (1) (b)]



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***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 that the resident's SDM and any other person specified by the resident is notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a resident, to be implemented voluntarily.***

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**WN #3: 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).**

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**Findings/Faits saillants :**



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1. The Licensee who had reasonable grounds to suspect abuse of a resident by anyone, by the licensee or staff that resulted in harm or risk of harm, failed to ensure that a report was made immediately to the Director when the following occurred:

Staff reported suspected abuse of Resident #01 twice.

Record review revealed that Critical Incident worksheets were initiated by the Registered staff after each incident.

In an interview with the Director of Care she confirmed that the Critical Incidents were initiated however they were not completed or reported to the Director. [s. 24. (1)]

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**Issued on this 20th day of May, 2014**

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

*Bonnie MacDonald*