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
Aug 13, 2014	2014_232112_0049	001906-14	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

CAROLE ALEXANDER (112)

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): August 06, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, a Registered Nurse, the BSO Team leader, 2 Personal Support Workers and 2 Family Members

During the course of the inspection, the inspector(s) reviewed a critical incident, the home's related internal investigation, policies and procedures for the elopement with related ELPAS/wander system system, 2 clinical records and the home's BSO referral system

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure the plan of care was based on an interdisciplinary assessment of safety risks.
A resident exited the home and was located over the highway.

The home's wanderguard "ELPAS" system was in place and functioning on the day of the incident, however because there was another resident with an ELPAS bracelet on at the same exit the alert for the other resident showed up. Staff did not know right away that Resident the resident had exited the home. The home currently has 20 residents with the ELPAS bracelets on and management and staff state 6 residents to be at higher risk of wandering and elopement.

The resident has made numerous attempts to elope from the home.
The resident's clinical record contains a period of time when the charting of the resident's behaviours were identified (DOS charting) and other tools to collect similar data.
An interdisciplinary assessment of the data was not completed.
The resident also wanders in other resident bedrooms and a successful intervention to keep the resident from entering this bedroom includes signage that the resident understands. This intervention has not been used for any of the home's exit doors which the resident attempts to elope.
The resident's clinical record, staff interviews and a family interview was consistent in identifying that the resident has left through an exit door by following a family/visitor, out. On another occasion the resident has followed a resident smoker outside.
A formal consistent means of communicating the risks of elopement for residents has not been established
Other potentially successful diversions such as cueing (pyjamas) has not been included as regular interventions from preventative measures.
On the day of the investigation staff were not able to clearly state what clothing/colours the resident was wearing.
Another resident who is identified at risk of elopement has an intervention stated as "reinforce reasons for placement" The resident clinical record and staff interviews confirm that this intervention is not used and/or appropriate given the resident's cognitive status.
The Director of Care, a Registered Nurse and administrator confirmed that resident #001 & 002 did not include individualized interventions regarding known safety risks for these residents. [s. 26. (3) 19.]

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 in ensuring interdisciplinary assessments are conducted to identify safety risk interventions for residents at risk of elopement, to be implemented voluntarily.

Issued on this 13th day of August, 2014

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