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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 14, 2015	2015_257518_0009	008658-14	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE CITY OF WINDSOR
1881 Cabana Road West WINDSOR ON N9G 1C7

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

HURON LODGE LONG TERM CARE HOME
1881 CABANA ROAD WEST WINDSOR ON N9G 1C7

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

ALISON FALKINGHAM (518)

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): March 3, 2015

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Director of Resident Services, a Clinical Coordinator, four Registered Staff members and two Personal Support Workers. The Inspector also reviewed a resident's clinical record, the homes policies regarding abuse and observed general and specific resident care.

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

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

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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the homes written policy to promote zero tolerance of abuse and neglect of residents was complied with. 2007, c. 8, s. 20 (1).

A Personal Support Worker witnessed inappropriate behaviour between two residents.
The residents were separated immediately, assessed to have no injuries and the incident was reported to the most responsible Registered Staff member.
The Registered Staff member contacted both families to report the incident and contacted the supervisor on call to report the incident.
The supervisor on call did not contact the after hours hot line to report the incident and the CIS was not completed or submitted until 3 days later.
This was confirmed by the Director of Resident Services, the Director of Care and the Clinical Coordinator.
The homes policy, Critical Incident Reporting After Hours last revised November 2014 indicates that the supervisor on call is to immediately notify the Ministry of Health pager after hours with all pertinent information in regards to the incident.
The Director of Resident Services confirmed it is the expectation that all incidents of resident abuse that occur after business hours should be reported to the Ministry of Health after hours pager. [s. 20. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

On a resident unit a soiled utility door was noted to be open. When the Inspector entered this room several bottle of liquid chemicals were observed and were easily accessible to residents. All of the chemical containers had labels that indicated the liquid inside was poisonous and toxic if ingested.
This was confirmed by a Personal support Worker.

The Director of Care confirmed that all hazardous substances kept in the home should be kept inaccessible to residents behind locked doors at all times and a memo was sent out immediately to all staff members to ensure that these doors are to be kept closed and locked at all times. [s. 91.]

Issued on this 14th day of April, 2015

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

Original report signed by the inspector.