Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 24, 2020	2020_563670_0004	024432-19	Complaint

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

DEBRA CHURCHER (670)

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): January 13, 14, 15, 16 and 23, 2020.

The purpose of this inspection was to inspect complaint Log# 024432-19 IL-73287-LO related to concerns regarding resident to resident abuse, personal support services, resident care and laundry services.

During the course of the inspection, the inspector(s) spoke with the Administrator, contracted Environmental Services Manager, one Assistant Director of Care, three Registered Nurses, two Registered Practical Nurses, nine Personal Support Workers and one Environmental Service Worker.

During the course of this inspection the Inspector observed the overall cleanliness and maintenance of the home, toured the laundry facilities and observed laundry processes, observed staff to resident interactions, observed the provision of care, observed resident to resident interactions, reviewed relevant clinical records, reviewed relevant internal documentation and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for resident #001.

The Ministry of Long-Term Care received a complaint related to concerns regarding care.

Review of resident #001's plan of care provided direction to staff regarding a specific care requirement.

Review of resident #001's flow sheets for a specified time frame, showed no documentation of the specific care being provided or attempted for 19 occasions on the day shift and for 15 occasions on the evening shift.

During an interview with Personal Support Worker (PSW) #107 they shared that they were certain the care was being completed or attempted and acknowledged that the care was not always being documented.

During an interview on January 14, 2020, the Administrator #101 acknowledged that the staff had not always documented the specific care was completed or attempted and stated that it was the expectation that staff would document the provision of care or attempted care.

The licensee has failed to ensure that the following was documented: The provision of the care set out in the plan of care. [s. 6. (9) 1.]

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 following are documented: The provision of the care set out in the plan of care, to be implemented voluntarily.

Issued on this 24th day of January, 2020

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

Original report signed by the inspector.