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

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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
Oct 21, 2021	2021_533115_0003	011480-21	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

TERRI DALY (115)

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): September 28, 29, October 1 & 4, 2021.

This complaint inspection was completed in relation to a fall and Critical Incident #M631-000005-21 an incident which results in significant change.

An Infection Prevention and Control (IPAC) inspection was also completed as part of this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Physiotherapist, a Registered Nurse (RN), Registered Practical Nurses (RPN), a Housekeeper, Personal Support Workers (PSW), a Public Health Inspector, Hospital IPAC support, and residents.

The inspector also observed resident rooms and common areas, observed IPAC practices within the home, observed residents and the care provided to them, and reviewed a health care record and plan of care for an identified resident.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care plan for a resident set out clear directions to staff.

During interviews the Clinical Care Supervisor an RN, a PSW and a family member identified that the resident was using a specific means of transportation for outings and to transfer from their room to the dining room.

A review of the resident's care plan did not include the specific mode of transportation.

During an interview, the Director of Care acknowledged that there were no interventions in the resident's care plan related to resident's use or need for this specific means of transportation and therefore the care plan did not set out clear directions for staff.

Sources: progress notes, and care plan for a specific resident, interviews with the Clinical Care Supervisor, an RN, the Physiotherapist, a PSW and the DOC. [s. 6. (1) (c)]

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 written plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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Issued on this 1st day of November, 2021

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

Original report signed by the inspector.