Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: April 2, 2024
Inspection Number: 2024-1626-0001
Inspection Type: Complaint Critical Incident
Licensee: Corporation of the City of Windsor
Long Term Care Home and City: Huron Lodge Long Term Care Home, Windsor

Lead Inspector	**Inspector Digital Signature**
Adriana Tarte (000751)	
Additional Inspector(s) Samantha Perry (740)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 6-8, 2024 and March 11-15, 2024

The following intakes were inspected in this Critical Incident (CI) inspection:
- Intake #00094153 related to falls prevention and management; and
- Intake #00101650 related to resident care and support services; and
- Intake #00101275 related to resident care and support services.

The following intakes were inspected in this complaint inspection:
- Intake #00097511 related to medication management, reporting and complaints, continence care, skin and wound prevention and management, and food, nutrition and hydration; and

- Intake #00108928 related to resident care and support services.

The following intakes were completed in this inspection:

- Intake #00096764 related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident related to transferring.

Rationale and Summary
A review of a resident's care plan directed staff to transfer the resident using a specific method. A Personal Support Worker (PSW) explained that regular staff were aware of the individualized care provided to the resident during their transfers, not included in the care plan.

Another PSW stated that they were unaware of this resident's individualized care and routine. They acknowledged that they would refer to the care plan for information regarding the care of a resident and that there was no clear direction for the resident’s individualized care during transfers.

The Assistant Director of Care (ADOC) believed that if the care plan was more individualized for transfer care, this information would have helped guide the staff during the transfer as staff are expected to check the care needs of the resident in the care plan.

Sources: Resident's care plan; and interviews with staff.

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WRITTEN NOTIFICATION: Additional training — direct care staff

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff

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s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee has failed to ensure that all staff who provide direct care to residents received annual falls prevention and management training.

Rationale and Summary
The long-term care home's falls prevention program was reviewed. The 2023 falls prevention education record for all staff who provided direct care to residents was reviewed and it was noted that 12 out of 187 staff did not complete their annual falls prevention and management training. Director of Care (DOC) confirmed that not all staff completed their falls education training.

Failing to educate all staff on the falls prevention and management program put the residents' safety at risk as the staff were not made aware of the most current falls prevention education.

Sources: Surge 2023 falls prevention course completion record, and interview with DOC

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