Ontario

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

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

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

Original Public Report

Report Issue Date: October 10, 2024
Inspection Number: 2024-1626-0003
Inspection Type: Critical Incident
Licensee: Corporation of the City of Windsor
Long Term Care Home and City: Huron Lodge Long Term Care Home, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 1-2, 2024

The following intake(s) were inspected:

- Intake: #00123068/CI #631-000012-24 - Fall of a resident

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee has failed to ensure that the Director was informed of an injury that resulted in a significant change in health condition.

Rationale and summary

On an identified date, a resident sustained a fall that resulted in an injury for which resident passed away seven days after.

A Critical Incident Report was submitted to the Director seven days after the occurrence of the incident.

In interviews with staff, it was acknowledged that the resident required adjustments to their care because of their decline in their health status and that the critical incident report to the Director was not submitted on time.

There was no harm or risk of harm to the resident as a result of the late reporting.

Sources: review of CI report; review of the resident's health care records; interviews with the ADOC and other staff.

Ontario

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

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

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