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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 13, 2013	2013_216144_0067	L-000509-13	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

CAROLEE MILLINER (144)

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): September 11, 2013

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, two Director's of Care, the Director of Resident Services and one Registered Nurse and Registered Practical Nurse.

During the course of the inspection, the inspector(s) reviewed on resident health care record and the home's policies related to Oxygen Therapy and Restraints.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

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. 6. Plan of care

Findings/Faits saillants :

1. The licensee did not ensure that there is a written plan of care for each resident that sets out the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident. Three staff confirmed one resident's care plan did not include the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident related to a physicians order. [s. 6.]

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 related to ensuring the written plan of care for each resident sets out the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee did not ensure the Director was immediately informed, in as much detail as possible, in the circumstance of an unexpected or sudden death. Four staff confirmed a critical incident report for one unexpected resident death was not submitted according to the Ministry requirements.[s. 107. (1) 2.]

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Issued on this 13th day of September, 2013

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

CAROLEE MILLINER