Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Jul 30, 2019	2019_725522_0010	010632-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive ST. THOMAS ON N5R 5V1

Long-Term Care Home/Foyer de soins de longue durée

Elgin Manor
39262 Fingal Line, R.R. #1 ST. THOMAS ON N5P 3S5

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

JULIE LAMPMAN (522)

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): July 24, 25, and 26, 2019.

Critical Incident System report #M518-000020-19 related to resident to resident abuse was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Resident Care Coordinator, Registered Practical Nurses, Personal Support Workers, the Behavioural Supports Ontario Personal Support Worker and a resident.

The inspector also observed resident to resident and staff to resident interactions, reviewed resident's clinical records and policies and procedures related to the inspection.

The following Inspection Protocols were used during this inspection:
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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care related to an incident of resident to resident physical abuse, whereby resident #001 pushed resident #002.

Review of resident #001's hard copy chart noted doctor's orders for Dementia Observation System (DOS) Mapping seven times over a two month period.

Review of resident #001's DOS charting in their hard copy chart noted that the DOS mapping had not been completed in full during six out of seven observation periods.

Inspector was unable to find DOS Mapping for resident #001 that was ordered for a specific time frame.

In an interview, Registered Practical Nurse (RPN) #106 stated when initiated, DOS charting should be completed every hour for a resident. RPN #106 stated DOS Mapping was initiated the day after it was ordered to ensure they captured a full day of mapping. RPN #106 stated that the DOS mapping should be completed for the full time period that the physician ordered.

RPN #106 reviewed resident #001's DOS charting with inspector. RPN #106 acknowledged that there were times that staff did not complete the DOS charting for resident #001. RPN #106 stated that was why the physician sometimes reordered DOS mapping as the charting was not completed in full. RPN #106 stated that all staff had been reminded to complete that DOS mapping hourly. RPN #106 stated that it was the registered staff and PSWs responsibility to complete the DOS charting.

RPN #106 reviewed resident #001's chart with inspector and reviewed the doctor's clip board and noted that they could not find DOS mapping for resident #001 that was ordered for a specific time period.

In an interview, Resident Care Coordinator (RCC) #100 reviewed resident #001's DOS Mapping with inspector. RCC #100 acknowledged that the DOS Mapping for resident #001 had not been completed hourly and for the length of time ordered by the physician. RCC #100 stated that Personal Support Workers were responsible to complete the DOS charting on residents and registered staff were responsible to remind the PSWs if they were not charting.

RCC #100 reviewed resident #001's hard copy chart, the doctor's clipboard and filing and acknowledged that there was no DOS Mapping initiated for a specific time period, as ordered for resident #001.

The licensee has failed to ensure that DOS Mapping for resident #001 was completed as per the doctor's orders.

B) Review of resident #004's hard copy chart noted doctor's orders for Dementia Observation System (DOS) mapping during three separate time periods.

Review of resident #004's DOS charting in the resident's hard copy file noted that during two of the specified time periods the DOS charting had not been completed in full.

Inspector and Resident Care Coordinator (RCC) #100 reviewed resident #004's DOS Mapping. RCC #100 acknowledged that the DOS Mapping had not been completed in full and that staff should be charting throughout the shift.

The licensee has failed to ensure that DOS Mapping for resident #004 was completed as per the doctor's orders.

C) Registered Practical Nurse #103 informed inspector that they had initiated Dementia Observation System (DOS) Mapping on resident #003 during two specific time periods.

Review of resident #003's hard copy chart noted during the two specific time periods the DOS Mapping had not been completed in full.

Inspector reviewed resident #003's DOS Mapping with Resident Care Coordinator (RCC) #100. RCC #100 acknowledged that the DOS charting was not completed in full and that staff should have completed the DOS charting hourly each day.

The licensee has failed to ensure that DOS Mapping for resident #003 was completed when it was initiated by registered staff. [s. 6. (7)]

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 Dementia Observation System (DOS) Mapping is completed as per the plan of care, to be implemented voluntarily.

Issued on this 31st day of July, 2019

[redacted]

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

Original report signed by the inspector.