

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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 13, 2020	2020_834524_0011	003302-20, 003925- 20, 006345-20, 007839-20, 008611- 20, 010326-20, 010501-20, 012617-20	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive 3rd Floor, Suite 303 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

INA REYNOLDS (524)

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 2, 3, 6, 7 and 8, 2020, as an off-site inspection.

The following Critical Incident System (CIS) intakes were completed within this inspection:

**Log #003302-20 / CIS M518-000012-20 related to a resident to resident altercation
Log #003925-20 / CIS M518-000013-20 related to a resident to resident altercation
Log #006345-20 / CIS M518-000017-20 related to a resident to resident altercation
Log #007839-20 / CIS M518-000020-20 related to a resident to resident altercation
Log #008611-20 / CIS M518-000021-20 related to a resident to resident altercation
Log #010326-20 / CIS M518-000024-20 related to a resident to resident altercation
Log #010501-20 / CIS M518-000025-20 related to a resident to resident altercation
Log #012617-20 / CIS M518-000026-20 related to a resident to resident altercation.**

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Resident Care Coordinator / Behavior Supports Ontario (BSO) Lead and a Registered Practical Nurse-BSO.

The inspector(s) also reviewed clinical records including progress notes, assessments and care planning interventions for identified residents.

**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 not issued.

0 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

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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.

Issued on this 13th day of July, 2020

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

Original report signed by the inspector.