

**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**

London Service Area Office  
130 Dufferin Avenue 4th floor  
LONDON ON N6A 5R2  
Telephone: (519) 873-1200  
Facsimile: (519) 873-1300

Bureau régional de services de London  
130, avenue Dufferin 4ème étage LONDON ON N6A 5R2  
Téléphone: (519) 873-1200  
Télécopieur: (519) 873-1300

**Public Copy/Copie du rapport public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Sep 23, 2021	2021_607523_0025	014482-21	Complaint

**Licensee/Titulaire de permis**

Corporation of the County of Elgin  
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**

ALI NASSER (523), CATHERINE OCHNIK (704957)

**Inspection Summary/Résumé de l'inspection**

**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**

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): September 20 and 21, 2021.**

**This inspection was completed for a complaint related to medication administration.**

**This inspection was completed concurrently with critical incident inspection #2021\_607523\_0025 related to allegations of abuse and falls prevention.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Public Health Unit Manager and Registered Nurse, a Registered staff member and a family member.**

**The inspector(s) also toured the home, observed residents and care provided to them, reviewed clinical records, incident reports, investigation notes and reviewed specific policies and procedures of the home.**

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

**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)**

**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**
**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.

The Ministry of Long-Term Care received a complaint related to concerns about a specific medication administration.

A clinical record review for the specific resident and internal investigation notes showed that the resident received a specific medication ahead of its scheduled time that was specified in the plan of care

In an interview the DOC said the resident received the specific medication ahead of time in error.

Sources: staff interviews and record reviews. [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 that the care set out in the plan of care was  
provided to the resident as specified in the plan, to be implemented voluntarily.***

---



**Ministry of Long-Term  
Care**

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

**Ministère des Soins de longue  
durée**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Issued on this 24th day of September, 2021**

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

**Original report signed by the inspector.**