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
Dec 5, 2019	2019_800532_0016	018647-19	Other

Licensee/Titulaire de permis

Corporation of the City of Guelph
c/o The Elliott Long Term Care Residence 170 Metcalfe Street GUELPH ON N1E 4Y3

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

The Elliott Long Term Care Residence
170 Metcalfe Street GUELPH ON N1E 4Y3

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

NUZHAT UDDIN (532), KATHERINE ADAMSKI (753)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 22-26, 2019.

During this Service Area Office Initiated Inspection (SAOII), a critical incident inspection #2019_800532_0017 / log #022529-19 was also completed.

Please Note: A Written Notification related to LTCHA, 2007, O. Reg. 79/10, s. 107 (1) identified in Critical Incident System Inspection (CIS) #2019_800532_0017 / Log #022529-19 was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Pharmacist, Pharmacy technician, Recreation Director, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Residents.

Inspectors also toured the resident home areas, observed resident care provision, resident/staff interactions, reviewed relevant resident's clinical records, relevant policies and procedures, medication administration/dining observations as well as notes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Medication
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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 O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle was reviewed by the Residents' Council for the home.

An identified number of residents stated that the home had not provided the menu cycles for Resident's Council members to review during the Resident's Council meetings.

The Director of Recreation confirmed that the menu cycles were not reviewed during the Resident's Council meetings before the completed menus were posted and implemented in the home.

The meeting minutes for September, October, and November 2019, did not document that the home's menu cycle had been provided to the Resident's Council for review prior to completion and implementation of the menu's.

The home has failed to ensure that Resident's Council had reviewed the home's menu cycle. [s. 71. (1) (f)]

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 home's menu cycle is reviewed by the Residents' Council for the home, 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 has failed to ensure that the Director was immediately informed, in as much detail as possible of an unexpected or sudden death, including a death resulting from an accident or suicide.

An identified resident had a change in condition and died suddenly.

The DOC confirmed that there was no immediate reporting, or a CI initiated to the Director when the resident passed away.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection an unexpected or sudden death, including a death resulting from an accident or suicide. [s. 107. (1) 2.]

Issued on this 6th day of December, 2019

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

Original report signed by the inspector.