Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2020	2020_760758_0014	012648-20, 013197-20	Critical Incident System

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

DANIELA LUPU (758), SHARON PERRY (155)

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 15-17, 2020.

The following intakes were completed in this Critical Incident inspection:

Log #012648-20, related to falls and significant change in condition; and

Log #013197-20, related to abuse.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Clinical Coordinator, a Registered Practical Nurse (RPN), a Registered Nurse (RN), Personal Support Workers (PSW) and residents.

The inspector(s) reviewed relevant residents' clinical records, plans of care, pertinent policies and procedures, and observed resident and staff interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to identify and implement interventions to minimize the risk of altercations and harmful interactions between resident #003 and other residents.

Resident #003 exhibited multiple responsive behaviours towards other residents and staff on several occasions. Their behaviours were unpredictable and not easily altered and methods to manage the behaviours were not always effective. On one occasion, resident #003's behaviour caused an altercation with another resident which resulted in resident #003's injury and transfer to the hospital. The home’s Behavioural Support Ontario (BSO) policy, directed staff to complete a BSO referral and consider 1:1 staffing until further steps were taken to reduce the risk of injury to the resident or others.

A referral to the BSO team or to other behavioural specialized resources was not completed. Resident #003 needed constant monitoring to minimize harmful resident interactions, but continuous 1:1 staffing was not implemented.

Sources: the home's Behavioural Support Ontario (BSO) Program policy, resident #003’s progress notes and care plan, and an interview with the Director of Care and other staff. [s. 54. (b)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that an incident of abuse which resulted in harm to a resident was immediately reported to the Director.

A critical incident (CI) was submitted to the Ministry of Long-Term Care (MLTC) regarding an incident of alleged abuse of a resident resulting in an injury to the resident for which they were transferred to the hospital.

The incident should have been reported immediately to the Director, but it was not reported until three days later.

Sources: critical incident report, resident's progress notes and an interview with Clinical Coordinator. [s. 24. (1) 2.]

Issued on this 5th day of October, 2020

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

Original report signed by the inspector.