Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Public Report

Report Issue Date: December 5, 2024

Inspection Number: 2024-1628-0002

Inspection Type:
Critical Incident

Licensee: The Corporation of the City of Guelph

Long Term Care Home and City: The Elliott Long Term Care Residence, Guelph

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20-22, and 25-28, 2024

The following intake(s) were inspected:

- Intake: #00127451 - Fall of a resident resulting in a significant change in status
- Intake: #00132727 -Resident to resident sexual abuse

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from sexual abuse by another resident.

"Sexual abuse" is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member

Rationale & Summary

A resident received an unknown number of calls from another resident. Some of these calls went to their voicemail and were later reviewed by staff of the home. The messages were of an inappropriate sexual nature.

Clinical records indicated that the recipient of the calls was upset from the voicemails.

A Registered Practical Nurse (RPN) and the Administrator both stated that when discussing the incident with the resident, they voiced being scared and distressed.

This incident of resident to resident sexual abuse caused psychological harm to a resident.

Sources: Clinical record review for the residents, interviews with a resident, an RPN

and the Administrator

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that strategies were implemented to reduce or mitigate falls for a resident.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure their policy is complied with to ensure fall prevention interventions were updated, and their effectiveness evaluated, after every resident fall.

Specifically, the licensee did not comply with their "Fall Prevention and Management Program" policy #005, implemented May 2006.

Rationale & Summary

A resident had multiple falls within seven months' time. Their final fall resulted in a hip fracture and their subsequent passing.

They had a post-fall assessment completed after each fall; however, none of these

assessments included any changes to the resident's fall prevention interventions. A bed alarm was never trialed or implemented by staff as a means of minimizing the resident's risk of falls.

The home's Fall Prevention and Management Program policy #005, stated that with every fall, registered staff are responsible for updating the resident's plan of care with changes to the resident-specific fall prevention interventions, as well as evaluate their effectiveness on an ongoing basis.

The Director of Care (DOC) acknowledged that a bed alarm may have been a useful fall prevention strategy for the resident.

By failing to update the resident's plan of care with new fall prevention strategies after each fall, the resident was at risk of falls and injury.

Sources: Clinical record review for the resident, the home's Fall Prevention and Management Program policy #005, implemented May 2006, interview with the DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours.

Rationale & Summary

Over the course of six month, a resident exhibited a variety of responsive behaviours towards staff. They also exhibited sexually responsive behaviours towards a co-resident.

Upon review of the resident's care plan, there were no responsive behaviours listed, nor interventions to respond to their behaviours. Their care plan stated that scored as low risk on their Violence, Aggression and Responsive Behaviour Tool (VAT) despite a more recent assessment scoring the resident as high risk. This was not reflected on the resident's care plan.

The Administrator stated that by not identifying these behaviours in the resident's plan of care, staff and residents were at risk of being subject to inappropriate behaviour.

By failing to ensure the resident's responsive behaviours were documented in their care plan, including strategies to manage those behaviours, staff and residents were placed at risk.

Sources: Clinical record review for the resident, interview with the Administrator

WRITTEN NOTIFICATION: Infection prevention and control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (7) 4.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
4. Auditing of infection prevention and control practices in the home.

As outlined in the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 7.3 (b) stated that the IPAC lead is responsible for ensuring that audits are performed, at least quarterly, to ensure that all staff can perform the IPAC skills required for their role.

The licensee failed to ensure that the IPAC lead completed these audits as required.

Rationale & Summary

The home was able to provide multiple IPAC audits during the inspection; however, the DOC confirmed they do not complete role-specific audits for all IPAC related tasks in each staffing department.

By failing to complete the IPAC audits as required by the IPAC Standard, there was risk of staff not performing their IPAC duties properly.

Sources: Interview with the DOC

WRITTEN NOTIFICATION: Police notification

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified of an incident of abuse of a resident that the licensee suspected may constitute a criminal offence.

Rationale & Summary

A resident was the recipient of an unknown number of inappropriate phone calls and messages from another resident that constituted sexual abuse, as defined in the regulations.

There was no documentation stating that the police services were informed about this incident of resident to resident sexual abuse.

The Administrator stated that they informed the resident that they could involve the police services; however, the police were never notified about the incident.

By failing to notify the police services, the police were not given the opportunity to investigate the incident themselves.

Sources: Clinical record review for the residents, interview with the Administrator