Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 28, 2016	2016_440210_0005	008965-16	Critical Incident System

Licensee/Titulaire de permis

ELM GROVE LIVING CENTRE INC
35 ELM GROVE AVENUE TORONTO ON M6K 2J2

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

ELM GROVE LIVING CENTRE INC.
35 ELM GROVE AVENUE TORONTO ON M6K 2J2

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

SLAVICA VUCKO (210)

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): March 30, 31 and April 1, 2016

During the course of the inspection, the inspector(s) spoke with Personal Care Aids (PCAs), Registered Practical Nurse (RPN), Registered Nurse (RN), Director of Care (DOC), Administrator, Environmental Services Supervisor, reviewed clinical records, policies, and observed the environment.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Personal Support Services
Safe and Secure Home

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)**

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	Legendé 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. 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):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. 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 is possible in the circumstances, of each of the following incidents in the home:
1. An emergency, including fire, unplanned evacuation or intake of evacuees.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

A review of the Critical Incident Report (CIR) submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, revealed that on an identified date, PCA #100 became aware of a fire in an identified area outside the home that is located on the property of the long-term care home. The PCA noticed that resident #001 was in the vicinity of the fire. Staff initiated fire emergency procedure. The resident was transported to hospital by ambulance and succumbed to injuries four days later. Further review of the CIR revealed that the home failed to update the CIR with the information that the resident had passed away two days earlier.

Interview with the Director of Care confirmed that the fire emergency and the unexpected death were not reported immediately as required to MOHLTC, in as much detail as is possible. [s. 107. (1)]

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 Director was 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): 1. An emergency, including fire, unplanned evacuation or intake of evacuees. 2. An unexpected or sudden death, including a death resulting from an accident or suicide, to be implemented voluntarily.

Issued on this 29th day of April, 2016

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

Original report signed by the inspector.