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 soins de longue durée**

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 24, 2018 | 2018_420643_0014 | 018241-18 | Resident Quality Inspection |

## 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
35 Elm Grove Avenue TORONTO ON M6K 2J2

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

ADAM DICKEY (643), CECILIA FULTON (618), JULIENNE NGONLOGA (502), ORALDEEN BROWN (698)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection.**

**This inspection was conducted on the following date(s): July 19, 20, 23-27, 30, 21, and August 1, 2, 2018.**

**Inspector #727 Joanna White attended this inspection during orientation.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Quality Care Supervisor, Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Programs Director, Food Services Manager, personal support workers (PSW), Residents' Council Representative, residents and family members.**

**During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dining Observation**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During stage one of the Resident Quality Inspection (RQI) resident #010 was triggered for incontinence from the most recent Minimum Data Set (MDS) assessment.

Review of resident #010's assessment data indicated that they were incontinent, and pads or briefs were used for the resident. Review of resident #010's current plan of care indicated that the resident was to receive brief changes with toileting, was frequently incontinent using a specified incontinent product which staff were to check and change before and after meals, at bedtime and as needed. Review of resident #010's progress notes indicated that they were hospitalized due to an infection and returned on an identified date, with a significant change in their status.

Observations by the inspector showed that resident #010 was not wearing an incontinent product throughout the course of the inspection. In an interview, resident #010 indicated that they did not wear an incontinent product.

In interviews, PSWs #102, #116 and #126 indicated that resident #010 did not wear the specified incontinent product as it was the resident's preference. PSW #102 indicated that the resident had been using the specified incontinent product following their return from hospital, but had not been using an incontinent product over the course of the last several months. PSW #126 indicated that if an incontinent product was placed on resident #010 they would remove it.

In an interview, RPN #103 indicated that resident #010 was frequently incontinent and

was using the specified incontinent product. RPN #103 indicated that they were not made aware that resident #010 was not using the specified incontinent product during their shift and preferred not to use one.

In an interview, the DOC indicated that a resident plan of care should give staff who work with the resident a clear picture of how to care for each resident. The DOC indicated that for resident #010, continence function may vary at different times of the day, being more independent and not using the specified incontinent product at certain times, but requiring the product at other times. The DOC indicated that the care plan for resident #010 did not give staff enough direction related to these varying levels of continence throughout the day. The DOC acknowledged that for resident #010, the written plan of care did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

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**Issued on this 27th day of August, 2018**

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

**Original report signed by the inspector.**