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
May 9, 2019	2019_655679_0010	000498-17, 006458-17, 009218-17, 009515-17, 010466-17, 022996-17, 023620-17, 025998-17, 001152-18, 032235-18	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
35 Elm Grove Avenue TORONTO ON M6K 2J2

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

MICHELLE BERARDI (679), AMY GEAUVREAU (642)

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): April 29 to May 3, 2019.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:

- Two intakes submitted to the Director related to alleged staff to resident abuse;

- One intake submitted to the Director related to visitor to resident abuse; and,

- Seven intakes submitted to the Director related to resident falls.

A Complaint inspection #2019_655679_0011 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Quality Care Supervisor, Social Worker, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents #008 and #001 as specified in the plan.

The licensee submitted a Critical Incident (CI) report to the Director, which identified that resident #008 had a fall resulting in an injury.

Inspector #642 reviewed the home's electronic medical files for resident #008 and identified that resident #008 had a fall on a specified date. The record identified that PSW #104 had performed a specified action, and that resident #008 fell trying to perform an action independently.

Inspector #642 reviewed resident #008's plan of care that was in effect at the time of the specified fall, which identified a specific action as an intervention to prevent falls.

Inspector #642 reviewed a document that the licensee had given PSW #104. The document stated that PSW #104 had performed a specified action, and the resident fell, therefore the PSW was not following the residents plan of care.

Inspector #642 interviewed PSW #104, who had been assisting the resident on the specified date. PSW #104 explained that they were assisting resident #008 with a specified task, that they performed a specific action, and the resident fell.

Inspector #642 interviewed RPN #110, who had completed the report on resident #008's fall. RPN #110 stated that PSW #104 had not followed the residents care plan, which stated that a specific intervention was to be implemented.

Inspector #642 interviewed PSW #118, RPN #105, and RN #117, who stated, staff were to follow the residents care plan's, when providing care to the residents.

Inspector #642 reviewed the home's policy, titled, "Nursing Procedures: Plan of Care" revised August 2018, which stated, the resident plan of care provides a profile of the resident and guides staff in the provision of care for the resident. The individualized plan of care reflects specific information about the resident and clear direction to all staff.

Inspector #642 interviewed the DOC who had investigated the incident. The DOC stated that PSW #104 had performed a specified action, and as a result the resident fell. The

DOC indicated that there was a specific intervention identified in resident #008's plan of care and that PSW #104 did not follow it.

2. The licensee submitted a CI report to the Director, which identified that resident #001 had a fall resulting in an injury.

Inspector #642 reviewed the CI report and it was identified in the report that resident #001 required a specified intervention; however, that the intervention was not implemented for a specified reason on the date of the fall.

Inspector #642 reviewed resident #001's plan of care that was in effect at the time of the fall. The care plan stated that a specified intervention was to be in place.

Inspector #642 interviewed PSW #118, RPN #105, and RN #117, who stated that staff were supposed to follow the residents care plan when providing care to the residents.

Inspector #642 interviewed the DOC who had completed the CI report, and they stated that a specified intervention was required for resident #001. The DOC indicated that the specified intervention was not implemented on the date of the fall due to a specified reason.

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 ensuring that the care set out in the plan of care is provided to residents as specified in the plan; specifically ensuring that fall prevention interventions are implemented as outlined in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

According to Ontario Regulation 79/10 s. 2, emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that was performed by anyone other than a resident.

According to Ontario Regulation 79/10 s. 2, verbal abuse is defined as any form of verbal communication of threatening or intimidating nature, or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

A CI report was submitted to the Director for an incident of alleged staff to resident verbal and emotional abuse. The CI report identified that on a specified date, the Administrator overheard PSW #101 state inappropriate comments while assisting the resident.

Inspector #679 reviewed a document which was addressed to PSW #101 by the Administrator. The document identified that the incident of verbal and emotional abuse was witnessed by the administrator, and that the staff member was provided with discipline.

A review of the policy titled "Zero Tolerance of Resident Abuse & Neglect" last revised August 2018, identified that Elm Grove had a zero tolerance policy with respect to resident abuse of any kind, and that all residents were to be treated with courtesy and respect at all times.

In an interview with Inspector #679, PSW #101 identified that they were assisting the resident, and accidentally made a comment to the resident. PSW #101 identified that

they were “very sorry for [making a comment towards the resident]”.

In an interview with Inspector #679, the Administrator identified that they had witnessed PSW #101's comments and the tone that they had used. The Administrator identified that the staff member was provided with discipline as a result of the incident.

2. A CI report was submitted to the Director for an incident of staff to resident verbal abuse. The CI report identified that it was reported to the home by an individual that they overheard an individual being verbally abusive towards resident #006. The CI report further identified that the Administrator also had overheard the individual being verbally abusive towards resident #006.

A review of the electronic progress notes identified that on a specified date, RN #111 documented that “it was reported by [an individual] (as per Administrator) that [an individual] has been verbally aggressive towards [resident #006]”. The note further identified that the “Administrator witnessed the [individual] doing the same- [stating inappropriate comments]”.

In an interview with RN #111, they identified that they recalled the Administrator reporting the incident of abuse. RN #111 indicated they were unable to recall any further details of the incident.

In an interview with the Administrator, they identified that the home received information from an individual about someone being rude to the resident. The Administrator identified that they had went to a specified area of the home to see what was occurring, and that they overheard the individual being verbally abusive to resident #006. The Administrator identified that the allegation of abuse was substantiated, and the individual was escorted out of the building.

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 ensuring that the homes policy "Zero Tolerance of Resident Abuse and Neglect" is complied with, to be implemented voluntarily.

WN #3: 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director: misuse or misappropriation of a resident's money.

A CI report was submitted to the Director on a specified date for an incident of misuse/misappropriation of a resident's money, that occurred one day prior to the submission of the CI report. The CI report identified that on a specified date, resident #002 and Social Worker #100 were made aware of an incident of alleged misuse or misappropriation of resident #002's money.

In an interview with Inspector #679, Social Worker #100 identified that they were made aware of an incident of alleged misuse or misappropriation of resident #002's money. Social Worker #100 further identified that upon their return to the home they notified the Administrator of the occurrence.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect" last revised August 2018, identified that financial abuse was defined as the misappropriation or misuse of a resident's money or property. The policy further identified under the section "Duty to Make Mandatory Reports" that any person who had reasonable grounds to suspect that misuse or misappropriation of a resident's money had occurred was required to immediately report the suspicion and the information upon which it was based to the Director.

In an interview with Inspector #679, the Administrator identified that if staff received a report of suspected or alleged abuse, they were to contact the management team, assess the resident and submit the CI report or call the after-hours line. The Administrator identified that they were made aware of the incident by the home's Social Worker, and that they could not recall what the delay in submitting the CI report was, but that it was not submitted immediately.

Issued on this 13th day of May, 2019

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

Original report signed by the inspector.