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
Feb 8, 2021	2021_833763_0002	011921-20, 025556-20, 000319-21	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

IANA MOLOGUINA (763)

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): January 14, 18, 19, 20, 21, 22, 25 and 26, 2021.

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

- Log #011921-20 (CIS #2515-000008-20) was related to a fall with injury.
- Log #025556-20 (CIS #2515-000014-20) was related to alleged staff to resident abuse.
- Log #000319-21 (CIS #2515-000001-21) was related to COVID-19 outbreak management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of this inspection, the inspector reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provision.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
5 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. (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).

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 a resident's plan of care set out clear directions to staff and others who provided direct care to the resident.

Record review indicated that the resident was at risk for falls and sustained a fall that resulted in injury requiring clinical intervention and a hospital admission.

Inspector #763 observed the resident during inspection using several falls prevention interventions that were not listed in their care plan. The unit's nurse confirmed that the resident used those interventions as their main means of preventing a fall or any associated injuries. They indicated that it was expected to list these interventions under the resident's care plan. They confirmed that the resident's care plan did not list these interventions and that this made it unclear which interventions were in place for the resident to manage their falls risk.

Sources: resident's clinical records (progress notes, care plan), observations, staff interviews (RPN #116, ADOC #101). [s. 6. (1) (c)]

2. The licensee has failed to ensure that a falls prevention intervention was used for a resident.

The resident was at risk for falls and had several interventions in place in their plan of care to manage that risk. Inspector #763 observed them during inspection resting in bed in their room. One of the interventions specified in the plan of care was not in place. The unit's regular RPN was interviewed and confirmed that the resident was supposed to have the specified intervention in place as per their plan of care but staff must have forgotten to implement it.

Sources: CIS #2515-000008-20, observations, staff interviews (RPN #102, ADOC #101). [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, and that the written plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Head Injury Routine (HIR) monitoring required under the home's fall policy was completed for a resident's falls.

O. Reg 79/10, s. 48 (1) required the licensee to ensure a falls prevention and management program was developed and implemented in the home to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the home’s policy "Falls Management and Prevention Program" (revised September 2020) that indicated HIR monitoring needed to be completed for all unwitnessed falls and witnessed falls that have resulted in a possible head injury.

The resident was at risk of falls and had several falls in 2020, one of which resulted in injury requiring surgical intervention. They sustained several unwitnessed falls resulting in no pain or injury for which HIR monitoring documentation was missing. Several staff confirmed HIR monitoring was required for these incidents but they were unable to find the HIR forms and believed staff forgot to complete the required monitoring.

Sources: resident's clinical records (care plan, progress notes, assessments, risk management assessments, physical chart records), CIS #2515-000008-20, the home's fall policy, staff interviews (RPN #107, RPN #113, ADOC #101). [s. 8. (1) (a),s. 8. (1) (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 where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004, #005, and #007 were assessed after a fall using a clinically appropriate assessment instrument specifically designed for falls.

Resident #004 was at risk of falls and had several falls in 2020; only two of the falls reviewed had a post fall assessment completed.

As a result of non-compliance identified for resident #004, the sample was expanded to include resident #005 and #007. Record review indicated that both residents were at risk for falls and experienced several falls:

- Resident #005 had two unwitnessed falls; a post fall assessment was only completed for one of the falls.
- Resident #007 had three unwitnessed falls; a post fall assessment was only completed for one of the falls.

The home’s ADOC confirmed that when a resident fell, staff were expected to complete a form titled “Post Fall ‘Huddle’ SBAR” after every fall as this was the home’s clinically appropriate instrument used to assess residents after a fall. All the above falls required a “Post Fall ‘Huddle’ SBAR” form to be completed.

In all incidents of falls, staff assessed the residents from head to toe for any pain or injury; however, several staff were interviewed and confirmed that the required post fall assessments for the above falls were not completed and could not be found. The nurse who assessed resident #005 after one of their falls acknowledged that they did not complete the required post fall assessment because they did not have the time; their unit went into COVID-19 outbreak around the same time period.

Sources: resident clinical records (care plans, progress notes, assessments, risk management assessments, physical chart records), CIS #2515-000008-20, staff interviews (RPN #107, RPN #113, RN #116, and ADOC #101). [s. 49. (2)]

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 all residents are assessed after a fall using a clinically appropriate assessment instrument specifically designed for falls, to be implemented voluntarily.

WN #4: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director of an incident that caused an injury to a resident for which they were taken to a hospital and which resulted in a significant change in their health condition.

Record review indicated that the resident sustained a fall that resulted in injury requiring clinical intervention and a hospital admission. There was no CIS report submitted to the Director for this incident.

The home's ADOC confirmed it was one of their responsibilities to submit CIS reports for similar incidents, and that they were aware no report was submitted for this incident. They were unsure why it was not submitted, but confirmed that the resident did experience a significant change in their health status as a result of their fall, and that a CIS report should have been submitted.

Sources: resident's clinical records (progress notes, assessments, risk management assessments, physical chart records), staff interviews. [s. 107. (3.1)]

2. The licensee has failed to ensure that the CIS report #2515-000008-20 submitted for a fall incident that required surgical intervention was submitted outlining the appropriate resident and staff names and information.

While inspecting the submitted fall incident for the above CIS report, inspector #763 discovered that the report was submitted for the wrong resident. The report was submitted under another resident's name. The included fall history for the resident was also incorrect, indicating that they had no recent falls, whereas they had several falls before this incident. The CIS report also indicated that a PSW was involved in the incident, but only provided their initials, and not their full name. During the inspection, inspector #763 interviewed several PSW staff with the same initials, however none of the staff were able to confirm that they were the ones present for the reported incident.

The home's management team confirmed that the CIS report was submitted under the wrong resident's name due to a clerical error, and that they were aware of their responsibility to submit full names of all residents and staff involved in the incident under the CIS report.

Sources: resident's clinical records (care plan, progress notes, assessments, risk

management assessments, physical chart records), CIS #2515-000008-20, staff interviews (RPN #113, ADOC #101). [s. 107. (4) 2.]

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 is informed of all incidents that cause an injury to a resident for which the resident is taken to a hospital and which results in a significant change in the resident's health condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program when they operated fans on units with a declared COVID-19 outbreak.

The home was in a COVID-19 outbreak during the time of the inspection, with COVID-19 positive residents residing on first and second floor units under isolation protocol. Inspector #763 observed the home's units and noted that fans were left on at the home's nursing stations on first and second floor, blowing air throughout the unit. Residents and staff were observed in the vicinity.

The second floor RN indicated that the home's management team advised the staff not to operate fans during a COVID-19 outbreak as it could increase the likelihood of infection. The home's IPAC lead confirmed this was communicated to staff as per the current best practice guidelines for prevention and control of respiratory outbreaks.

Sources: observations, staff interviews (RN #116, ADOC #101). [s. 229. (4)]

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 staff participate in the implementation of the home's IPAC program, to be implemented voluntarily.

Issued on this 9th day of February, 2021

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

Original report signed by the inspector.