Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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
Jan 25, 2022	2021_631210_0031	019200-21	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

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): December 14, 15, 16, 17, 20, 21, 22, 23, 24 (onsite), December 29, 30, 31, 2021 and Jan 5, 2022 (off site).

The following Critical Incident System (CIS) reports were inspected:

-intake 013679-21 (CIS # 2515-000005-21) related to alleged sexual abuse,
-intake #019200-21 (CIS #2515-000011-21) related to alleged emotional abuse.

During the course of the inspection, the inspector conducted observations of the home, including resident home areas, staff to resident interactions, reviewed the home's internal investigation notes, and the home's relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support workers (PSWs), Behavioral Support Ontario (BSO) Lead, Infection Prevention and Control (IPAC) Lead, and residents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 the resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to Ministry of Long Term Care (MLTC) on an identified date, that resident #001 was provided inappropriate care from staff.

Resident #001's care plan indicated that a particular staff should provide care to the resident.

Resident #001 was not provided care according to their written plan of care.

2. Resident #002's care plan, indicated only a particular staff should provide care to the resident. On a specified date, care was provided by a staff, who was not aware about resident #002's care plan.

Resident #002 was not provided care according to their written plan of care.

Sources: interviews with staff and review of resident #001 and #002's care plan.[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 was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003 was protected from abuse by anyone.

For the purposes of the definition of abuse in subsection 2(1), of the Act, “emotional abuse” means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A CIS report was submitted to MLTC about an alleged altercation between resident #003 and a staff on a specified date.

Review of video footage showed that on a specified date, resident #003 was in the hallway. Staff #108 was passing by resident #003 who was using profane language, turned towards the resident and made a threatening motion for them to stop. The resident got irritated and tried to hit the staff. RN #101 intervened and prevented further escalation. Later resident #003 did not remember about the incident. As per the home’s investigation staff #108 was not able to explain their action related to the incident.

Resident #003 was not protected from emotional abuse by staff #108 on a specified date.

Sources: review of home’s hallway camera footage, home’s investigation notes, resident #003’s clinical record, interview with RN #101 and other staff, resident #003 and other residents. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that 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 was immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to MLTC on a specified date, that resident #001 reported to the home's staff alleging inappropriate treatment from staff.

Resident #001 reported their concern to ADOC #100 on a specified date. The resident did not disclose the name of the staff right away. The resident requested a surveillance camera to be installed in their room, and to be believed about their statement. After further questioning by ADOC #100, one week later, the resident disclosed the name of the concerning staff #109, and the home submitted a CIS report to MLTC about the alleged inappropriate treatment. Further actions were taken by the home.

2. On a specified date resident #002 was yelling and screaming that staff #109 provided inappropriate treatment to them and other resident.

The home did not report immediately to the Director about the suspicion of inappropriate treatment of resident #001 and #002 by staff.

Sources: CIS report, interview with ADOC #100, staff #104, and other staff, review of resident #001 and #002's clinical records and home's investigation notes. [s. 24. (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 person who has reasonable grounds to suspect that 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 immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 3rd day of February, 2022

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

Original report signed by the inspector.