Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Toronto District**
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
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# Original Public Report

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| **Report Issue Date: September 19, 2023** | |
| **Inspection Number:** 2023-1082-0003 | |
| **Inspection Type:**<br>Critical Incident | |
| **Licensee:** Elm Grove Living Centre Inc. | |
| **Long Term Care Home and City:** Elm Grove Living Centre, Toronto | |
| **Lead Inspector**<br>Dorothy Afriyie (000709) | **Inspector Digital Signature**<br>Dorothy A Afriyie |
| **Additional Inspector(s)**<br>Yannis Wong (000707)<br>Wing-Yee Sun was present during this inspection | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28-31, 2023

The following intake(s) were inspected:

- Intake #00087451, Critical Incident (CI) #2515-00008-23 and #00090053, CI #2515-000010-23 related to falls

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

## INSPECTION RESULTS

### Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the

conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

**NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)**
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

**Rationale and Summary:**
A resident fell, sustained an injury, and required a specialized device for transfer. At the time of inspection, the resident was observed to transfer independently. Their care plan was not updated when their mode of transfer changed from using a specialized device to independent transfer.

A Registered Practical Nurse (RPN) and Assistant Director of Care (ADOC) both stated that the resident's care plan should have been updated when the resident's mode of transfer changed. The Physiotherapist (PT) acknowledged that the resident was independent with transfers.

Failure to ensure that the resident's plan of care was reviewed and revised may lead to improper assistance being provided to the resident.

**Sources:**
Resident's record review; Observation on August 29, 2023; Interviews with RPN, ADOC, and PT.

Date Remedy implemented: August 31, 2023.

[000709]

## WRITTEN NOTIFICATION: Directives by Minister

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that a policy directive that applied to the long-term care home was complied with.

The Minister's Directive: COVID-19 response measures for long-term care homes requires every long-term care home to comply with section 1.1 COVID-19 outbreak preparedness plan. The plan must

include IPAC audits in accordance with the COVID-19 guidance document for long-term care homes in Ontario. The home was required to complete weekly IPAC audits when in a COVID-19 outbreak.

**Rationale and Summary:**
The home was in COVID-19 outbreak from May 26 to June 22, 2023. The home conducted IPAC audits with the COVID-19: Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes on June 7 and June 20, 2023. There were no audits completed for the week of June 11 to 17, 2023, when the home was in COVID-19 outbreak. The IPAC Lead confirmed there were no records of additional audits. They acknowledged the home should have conducted weekly audits during the COVID-19 outbreak period.

Failing to conduct weekly COVID-19 Self-Assessment Audits during a COVID-19 outbreak, placed residents at potential risk for transmission of infectious agents, including COVID-19.

**Sources:**
CIS, Minister's Directive for COVID-19 guidance document for long-term care homes in Ontario (dated March 31, 2023), COVID-19 Self-Assessment Audit Tool for Long-term Care Homes and Retirement Homes, and interview with IPAC Lead.

[000707]

## WRITTEN NOTIFICATION: Unsafe Transferring Techniques

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident after a fall.

**Rationale and Summary:**
A resident had a fall that resulted in an injury and subsequent transfer to hospital. The resident expressed that they may have sustained an injury, despite this, staff transferred the resident.

An RPN and a Personal Support Worker (PSW) acknowledged that the resident was transferred in an unsafe manner.

The Director of Care(DOC) verified that the home has procedures in place to ensure safe resident

transfers and acknowledged that this resident was unsafely transferred in a manner inconsistent with the home's policies and procedures.

Failure to use a safe transferring technique when assisting the resident increased the risk of further injury to the resident.

**Sources:**
Resident's clinical record review; Interview with RPN, PSW, and DOC; Home Minimal Lift Policy, revised December 2021; CIS.

[000709]

## WRITTEN NOTIFICATION: Falls Prevention and Management

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident had a fall, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

**Rationale and Summary:**
A resident had a fall that resulted in an injury and subsequent transfer to hospital.

Record review indicated that a head-to-toe assessment was not completed after the fall.

A RPN acknowledged that they did not complete a head-to-assessment after the resident's fall.

The ADOC indicated that the resident should have been assessed using a head-to-toe assessment tool after the resident sustained a fall.

Failure to complete a head-to-toe assessment using a clinically appropriate tool increases the risk of further injury to the resident.

**Sources:**
Resident's clinical record review; Interview with RPN and ADOC; CIS.

[000709]