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
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: April 16, 2024

Inspection Number: 2024-1082-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Elm Grove Living Centre Inc.

Long Term Care Home and City: Elm Grove Living Centre, Toronto

Lead Inspector	**Inspector Digital Signature**
Henry Chong (740836)	Henry A Chong Digitally signed by Henry A Chong Date: 2024.04.26 09:27:48 -04'00'

Additional Inspector(s)
Yang Xiang (000860) was present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 21, 22, 25-27, and April 2, 3, 2024

The following intake(s) were inspected in this Critical Incident System (CIS) Inspection:

- Intake: #00107231 [CI: 2515-000001-24] - Infection prevention and control
- Intake: #00108042 [CI: 2515-000002-24] - Fall prevention and management

The following intake(s) was inspected in this complaint inspection:

- Intake: #00110998 - neglect and resident care

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The following intake(s) were completed in this inspection: Intake: #00090123 - [CI: 2515-000018-23] was related to infection prevention and control.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A resident had a fall and sustained an injury. Their plan of care indicated that they were at risk for falls and specified the use of a fall prevention intervention.

On an identified date, the resident was observed without the falls prevention intervention in place. A Personal Support Worker (PSW) and Director of Care (DOC) both confirmed that the intervention should have been provided.

Failure to provide the falls prevention intervention may put the resident at further risk of harm from a fall.

Sources: Resident's care plan; observations; and interviews with PSW and DOC.

[740836]

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents at all times.

Rationale and Summary
A complaint was submitted regarding a resident's communication and response system not being accessible.

On an identified date, the resident's clinical records included a request to have the

system repaired for access. The home's maintenance request log indicated that the repair was completed several days later.

The DOC confirmed that the communication and response system would not have been accessible to the resident while awaiting repair.

There was risk to the resident when the communication and response system was not accessible to the resident in the event they needed assistance.

Sources: Resident's clinical records; Maintenance log records; and interview with DOC.

[740836]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to ensure that their hand hygiene program was implemented in accordance with any standard issued by the Director.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.2 stated that the licensee shall also ensure that the hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks.

Rationale and Summary
During a meal observation, residents were not assisted with hand hygiene prior to their meal.

A PSW stated that residents were not provided hand hygiene before eating. The IPAC lead said that staff were to assist residents with hand hygiene before their meals and there was an increased risk of infectious disease when it was not completed.

Sources: Observations; and interviews with PSW and IPAC Lead.

[740836]

WRITTEN NOTIFICATION: Reporting critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to report a critical incident after normal business hours using the Ministry's method for after hours emergency contact.

Rationale and Summary
On an identified date, a critical incident report was submitted by the home after normal business hours. The home did not use the Ministry's method for after hours emergency contact.

The Ministry of Long-Term Care (MLTC) Reporting Requirements - reference sheet sent out on August 18, 2023 indicated that for critical incidents reported immediately outside of business hours, to call the Service Ontario After-Hours Line.

A Nurse Supervisor confirmed that the home submitted a critical incident report but did not call the Service Ontario After-Hours Line.

Sources: Critical Incident Report 2832-000016-23; MLTC Reporting Requirements - reference sheet; and interview with Nurse Supervisor.

[740836]