Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2013	2013_157210_0024	T383-13, 326-13	Complaint

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 INC.
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 Complaint inspection.

This inspection was conducted on the following date(s): October 08, 09, 2013

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurse (RPN), Assistant Director of Care (ADOC), Director of Resident Care (DORC)

During the course of the inspection, the inspector(s) observed the provisions of personal care, reviewed health records

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

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 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 :

1. The person who had reasonable grounds to suspect that abuse of a resident by the staff that resulted in risk of harm has occurred failed to immediately report the suspicion and the information upon which it was based to the Director.

Interview with an identified staff indicates that in July, 2013 she\he witnessed another staff using a physical force to release Resident #1's hand and it seemed like punching the resident's hand. Resident was in the wheelchair in front of the spa room in the hallway. The incident was reported to RPN and ADOC the same day. RPN assessed the resident the same shift and didn't find any bruises or injuries. Incident was reported to the Director of MOHLTC five days after happened. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM (grand daughter) specified by the resident was notified within 12 hours upon becoming aware of alleged, suspected or witnessed incident of abuse of the resident.
Interviews with ADOC, RPN and PSWs indicate that in July, 2013 an identified staff witnessed alleged physical abuse towards Resident #1. Resident #1 was in the wheelchair and wanted to go to the washroom that is located in the spa room in the hallway. Interview with another identified staff indicates that Resident #1 blocked the entrance to the washroom. Staff wanted to open and hold the door of the washroom and at the same time to transport Resident #1 inside. Resident held the wheels tightly with both hands. According to the interview, the staff who was assisting the resident wanted to release the wheels of resident's hands. An identified staff who witnessed the incident stated that it looked like the resident was punched.
Interview with ADOC indicates that the incident was reported to her the same day, and to DOC two days later. Incident was not reported to the resident's SDM within 12 hours upon becoming aware of it. [s. 97. (1) (b)]

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Issued on this 18th day of November, 2013

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

SCAVICA VUCKO