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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 12, 2017	2017_533115_0003	025528-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ELGIN MUNICIPAL HOMES
39262 Fingal Line RR #1 ST. THOMAS ON N5P 3S5

Long-Term Care Home/Foyer de soins de longue durée

ELGIN MANOR
39262 FINGAL LINE R. R. #1 ST. THOMAS ON N5P 3S5

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

TERRI DALY (115), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 14, 15, 16, 21 and 22, 2017

The following intakes were completed within the RQI:
Log #015386-16 - Complaint IL-44685-LO related to sufficient staffing
Log #021562-17 - Complaint IL-52822-LO related to alleged resident to resident abuse
Log #026407-17 - Critical Incident M518-000034-17 related to alleged resident to resident abuse.

London Service Area Office (LSAO) Inspection Manager #688 (Kevin Bachert) was also present for part of this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Resident Care Coordinator, the Manager of Support Services, the Resident Assessment Instrument Coordinator, the Manager of Program and Therapy, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a representative of Residents' and Family Council, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **1 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	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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist the resident who was at risk of harm or who was harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A review of three Critical Incident System (CIS) reports submitted to the Ministry of Health and Long -Term Care (MOHLTC), related to three incidents occurring between two residents causing harm to one of the residents, was completed.

A review of progress notes for both residents, showed these same three incidents, causing harm to one of the residents.

The plan of care for a specific resident showed goals and interventions related to responsive behaviours, including interventions recommended by internal and external resources.

The plan of care for the other resident did not include goals and interventions to assist the resident who had been injured, as a result of the three incidents.

There were no other interventions identified to minimize the risk of altercations and potentially harmful interactions between the two residents identified on a specific resident's plan of care.

During staff interviews, staff did not identify specific interventions to assist the other resident with potentially harmful interactions related to another resident.

Manager of Resident Care (MRC) acknowledged that minimal interventions were in place to ensure the resident's safety due to the risk of harm related to another resident's responsive behaviours.

The severity was determined to be a level three as there was actual harm. The scope of this issue was isolated during the course of this inspection. The home had unrelated non-compliance in the last three years. [s. 55. (a)]

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 there are procedures and interventions are developed and implemented to assist the resident who is at risk of harm or who has been harmed as a result of another resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A resident was observed utilizing a specific device on specific days.

A Personal Support Worker (PSW) stated that the resident utilized a specific device for safety.

An interview with a Registered Nurse (RN), they stated that the resident used a specific device. They expressed that this information would be part of the resident's plan of care, however they could not locate this information when asked.

Review of the resident's plan of care did not identify the use of a specific device.

In an interview with the Resident Care Coordinator (RCC), they stated that all devices utilized by a resident should be identified on the care plan, and that the home did not provide clear direction related to the use of the a specific device for a specific resident.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on February 3, 2015, in the Resident Quality Inspection (RQI) as a Written Notification (WN). [s. 6. (1) (c)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented together with a record of the immediate actions taken to assess and maintain the resident's health, reported to the resident or the resident's substitute decision-maker, and the resident's attending physician.

Medication incidents in the home were reviewed for a specific time period.

A medication incident occurred on a specific date. The medication incident report indicated "Family notified: no" and "Name of physician notified:" was blank. It also stated: "Physician response: did not contact, no direction to" and there was no documentation in the resident's health record that the physician was notified of the incident. In an interview with the Administrator they said the expectation was that family were to be notified of medication incidents for this resident. In an interview with the Administrator and the Manager of Resident Care (MRC) the MRC said that the report documented that the physician was not notified and that the expectation was that the physician would be notified the following day or during the doctor's next rounds. The MRC was unable to find a notation in the doctor's rounds book related to the incident and when the MRC called the physician, the physician could not recall when they were notified. The MRC also stated that the family was not notified until a later date, acknowledging that the family also should have been notified at least the next day.

Another medication incident occurred on a specific date. There was no documentation of actions taken to assess and maintain the resident's health on the medication incident report or in the resident's health record. During an interview the Administrator and the Manager of Resident Care, they said that there was no documented assessment of the resident related to the incident.

The licensee has failed to ensure that medication incidents involving two specific residents were documented together with a record of the immediate actions taken to assess and maintain the resident's health, reported to the resident or the resident's substitute decision-maker, and the resident's attending physician.

The severity was determined to be a level one as there was minimum risk. The scope of this issue was a pattern during the course of this inspection. The home had unrelated non-compliance in the last three years. [s. 135. (1)]

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

---

Issued on this 19th day of December, 2017

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

Original report signed by the inspector.