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 prévue 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

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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
Dec 19, 2018	2018_263524_0023	009388-18, 010277-18, 013059-18, 021954-18, 023080-18, 024305-18, 030982-18	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive ST. THOMAS ON N5R 5V1

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

INA REYNOLDS (524)

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 6, 7, 10, 11 and 12, 2018.

The following Critical Incidents were completed within this inspection:
Log #009388-18 / CIS #M518-000007-18 related to falls prevention and management
Log #010277-18 / CIS #M518-000009-18 related to responsive behaviours and allegations of abuse
Log #013059-18 / CIS #M518-000010-18 related to falls prevention and management
Log #021954-18 / CIS #M518-000023-18 related to falls prevention and management
Log #023080-18 / CIS #M518-000024-18 related to falls prevention and management
Log #024305-18 / CIS #M518-000027-18 related to responsive behaviours and allegation of abuse
Log #030982-18 / CIS #M518-000037-18 related to falls prevention and management

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Care Coordinator, one Registered Practical Nurse, seven Personal Support Workers and residents.

The inspector(s) also observed resident care provisions, resident and staff interactions, reviewed residents' clinical records and plans of care, and relevant policies and procedures of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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	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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

This inspection was initiated as a result of a Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, regarding a fall incident for an identified resident.

Review of the resident's clinical record showed the following:
-The resident's laminated picture care plan posted in their room on a specific date, documented "zero" for a certain assistive device.
-The care plan and Kardex on Point Click Care did not document interventions related to the assistive device when in bed.
-The Resident Assessment Instrument – Minimum Data Set assessment for a specific date, indicated that assistive devices were not used for bed mobility or transfer.
-The resident was assessed at risk for falls on a specific date, related to multiple identified factors.

Observation of the resident's bed system on a specific date and time, noted an assistive device engaged in the bed and again on another specific date and time, while the resident was in bed and asleep.

In an interview, the inspector asked a Personal Support Worker (PSW) how they would know what care a resident required related to the use of assistive devices. The PSW said that they would use the picture care sheet posted in the resident's room and in the

Kardex on Point of Care for care interventions including directions for assistive device use. The PSW verified that the picture care sheet posted in the resident's room documented "zero" for a certain assistive device. The PSW said that an assistive device was observed up at the start of their shift when providing care to the resident and thought that perhaps the assistive device was utilized for safety reasons.

In an interview on a specific date, the Resident Care Coordinator said that the resident had not required the use of assistive devices when in bed and acknowledged it was the home's expectation that staff follow the plan of care at all times.

The licensee failed to ensure that the care set out in the plan of care was provided to the identified resident as specified in the plan related to the use of assistive devices. [s. 6. (7)]

2. The licensee had failed to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

This inspection was initiated as a result of a Critical Incident System (CIS) report submitted to the MOHLTC on a specific date, regarding a fall incident for an identified resident.

Review of the resident's clinical record showed the following:
-The resident was assessed at risk for falls on a specific date, related to their diagnosis and multiple risk factors.
-The risk management report showed that the resident had multiple falls between a specific period of time.
-The care plan under the falls risk focus stated that the resident was not to wear an identified personal assistive service device (PASD) for safety reasons.
-The care plan under the falls risk focus also stated that the resident wears the identified PASD.
-The care plan under a different focus directed staff to remind the resident to utilize their PASD.

In an interview on a specific date, a Personal Support Worker (PSW) said they would reference the Kardex on Point of Care for resident care needs. The PSW reviewed the Kardex with the inspector and said that the resident had not worn the identified PASD for multiple months and that staff were not to remind the resident to wear the PASD. The

PSW said that the Kardex should be updated as the PASD was still available and some staff might utilize the PASD.

In an interview on a specific date, the Administrator said that the resident did not wear the PASD and staff were not to remind them to wear the PASD. The Administrator said that the plan of care should have been updated to reflect the resident's current status related to the use of the PASD.

The licensee has failed to ensure that the plan of care for the identified resident was reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

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 is provided to the resident as specified in the plan and that the resident's plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs changed, to be implemented voluntarily.

Issued on this 20th day of December, 2018

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

Original report signed by the inspector.