Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Oct 15, 2019	2019_563670_0037	016902-19, 017359-19, 017517-19, 017550-19, 018088-19, 018296-19, 018858-19, 019077-19, 019446-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive 3rd Floor, Suite 303 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

DEBRA CHURCHER (670)

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): October 7, 8, 9, 10 and 11, 2019.

The purpose of this inspection was to inspect the following;
Log# 018296-19 CIS# M518-000037-19 related to a resident to resident altercation.
Log# 016902-19 CIS# M518-000031-19 related to a resident to resident altercation.
Log# 017359-19 CIS# M518-000032-19 related to a resident to resident altercation.
Log# 018088-19 CIS# M518-000035-19 related to a resident to resident altercation.
Log# 018858-19 CIS# M518-000038-19 related to a resident to resident altercation.
Log# 017550-19 CIS# M518-000034-19 related to a resident to resident altercation.
Log# 017517-19 CIS# M518-000033-19 related to a resident to resident altercation.
Log# 019007-19 CIS# M518-000040-19 related to a resident to resident altercation.
Log# 019466-19 CIS# M518-000041-19 related to a resident to resident altercation.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Resident Care Coordinator, one Registered Practical Nurse Behavior Supports Ontario Lead and five Personal Support Workers.

During the course of this inspection the Inspector observed the overall cleanliness and maintenance of the home, observed staff to resident interactions, observed the provision of care, reviewed relevant resident clinical records, reviewed relevant internal home records and reviewed relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that resident #002, #003, #004 and #005 were protected from abuse by anyone.

The home submitted nine separate Critical Incident System reports (CIS) to the Ministry of Long-Term Care (MOLTC) related to specific incidents involving resident#001. Review of the submitted CIS reports show that resident #001 was involved in five specific incidents with resident #002, three specific incidents with resident #003, one specific incident with resident #004 and one specific incident with resident #005.

Review of documentation in the home completed by PSW #106 that was not an employee of the home showed that resident #001 had specific incidents with other residents on a specific date.

During an interview with PSW #106 they confirmed that they were in the home for a specific time daily for a specific resident and was aware of the incidents that were documented however did not report the incidents to the home.

During an interview with Registered Practical Nurse (RPN) and Behavior Supports Ontario Lead (BSO) #103 they stated that the physician and external resources were highly involved with resident #001 however there was only one intervention that had been successful related to the residents specific condition. RPNBSO #103 acknowledged that the specific intervention was difficult to provide due to staffing issues and was not always in place.

During an interview on October 9, 2019, the Director of Care (DOC) #102 acknowledged that the specific intervention, that had proven to be effective for resident #001, was not in place at the time of the incidents listed in the CIS reports.

The Licensee has failed to ensure resident #002, #003, #004 and #005 were protected from abuse by anyone.

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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 15th day of October, 2019

[redacted]

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

Original report signed by the inspector.