Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

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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
May 22, 2020	2020_609569_0003	000269-20, 003247-20	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

DONNA TIERNEY (569), MELANIE NORTHEY (563)

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): February 27 and 28, 2020.

The following intakes were completed during this inspection:
Intake log #000269-20 / Critical Incident M518-000001-20 related to prevention of abuse and neglect;
Intake log #003247-20 / Critical Incident M518-000010-20 related to failure/breakdown of major system - Heating, air conditioning and ventilation system.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nursing Staff, the Building Sciences Technologist, Maintenance, Personal Support Workers, and Housekeeping.

The inspector(s) also conducted a tour of the home and made observations of residents and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Room temperature readings were also reviewed.

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

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

- **1 WN(s)**
- **0 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the abuse or neglect investigation were

reported to the Director.

The Long-Term Care Homes Act, 2007, s. 23 (1)(a) states, “Every licensee of a long-term care home shall ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated” and includes, “neglect of a resident by the licensee or staff”.

The Long-Term Care Homes Act, 200,7 s. 23 (2) states, “A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The Long-Term Care Homes Act, 2007, s. 23 (1)(b) states, “Every licensee of a long-term care home shall ensure that appropriate action is taken in response to every such incident”.

A Critical Incident System (CIS) report documented an incident of resident to resident abuse that was reported to the Ministry of Long-Term Care (MLTC). A specified resident had sustained an injury of unknown cause. Based on information received, the home launched an internal investigation related to alleged resident to resident abuse.

During the home's internal investigation into the matter, it was concluded that there was no evidence to support the allegation of resident to resident abuse of this specified resident as was initially reported to the MLTC. The home did however find evidence to support staff neglect towards the specified resident which resulted in disciplinary action. The results of the home’s internal investigation were not included in the final CIS report to the Director.

The Elgin County Homes and Seniors Services Policy and Procedure Number 2.11 "Resident Abuse" last reviewed October 2019, stated in part “the Director of Homes and Seniors Services/ Administrator/designate shall report the allegation to the Ministry of Health and Long-Term Care Director."“The Ministry of Health & Long-Term Care shall be notified as per Mandatory Reporting Guidelines as outlined under the Long-Term Care Homes Act, 2007. See Appendix A: Reporting Certain Matters to the MOHLTC (Director)" related to "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".

The Administrator acknowledged that the suspected staff to resident neglect was confirmed as part of the home's investigation. The Administrator also verified that the

results of the investigation were not reported to the Director of the Ministry of Long-Term Care.

The licensee failed to ensure that the results of the abuse or neglect investigation related to staff to resident neglect for the specified resident were reported to the Director. [s. 23. (2)]

Issued on this 26th day of May, 2020

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

Original report signed by the inspector.