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
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Telephone: (519) 873-1200
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130, avenue Dufferin 4ème étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 28, 2022	2022_974670_0007	018104-21, 018162-21	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Elgin
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): March 21 and 22, 2022.

The purpose of this Inspection was to inspect the following:
Log# 018104-21 CIS# M518-000069-21 related to alleged staff to resident neglect.
Log# 018162-21 CIS# M518-000070-21 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, two Registered Practical Nurses, one Public Health Nurse, two Screeners, six Personal Support Workers, one Housekeeper and residents.

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

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 VPC(s)
1 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

O. Reg. 48 (1) 1. states: "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home. A falls prevention and management program to reduce the incidence of falls and the risk of injury."

A)The homes policy titled Falls Prevention and Management, last reviewed March 2022, stated “Reassessment with a fall risk assessment occurs quarterly, upon readmission, whenever there is a change in the resident’s health status which puts them at increased risk for falling and, whenever a resident has a serious fall injury/multiple falls.” “Initiate a head injury routine for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy. (Use neurological flow sheet).” Head injury schedule was listed as every 30 minutes for two hours, followed by every hour for four hours, followed by every 4 hours for eight hours then followed by every eight hours for 72 hours.

Review of post fall documentation showed that a resident had three unwitnessed falls and one witnessed fall.

Review of the Head Injury Routine (HIR) documentation showed that HIR assessments were due to be completed at three specific times.

This Inspector was unable to locate any HIR assessments for the three specific times.

Review of the HIR documentation for the most recent fall, showed that completed assessments had been documented at eight specific times on specific dates.

During an interview with Administrator #100 related to the resident’s most recent fall, it was shown that the HIR assessments documented for eight specific times were falsely documented and had not been completed.

Review of Fall Risk Assessments showed that the most recent assessment prior to the three unwittnessed and one witnessed falls was dated for three months prior to the falls.

B) Review of post fall documentation showed that a resident had unwitnessed falls on two specific dates.

Review of the Head Injury Routine (HIR) documentation showed that HIR assessments were due to be completed at five specific times.

This Inspector was unable to locate any HIR assessments for the five specific times.

C) Review of post fall documentation showed that a resident had four unwitnessed falls on specific dates.

Review of the Head Injury Routine (HIR) documentation showed that HIR assessments were due to be completed at 17 specific times.

This Inspector was unable to locate any HIR assessments for the 17 specific times.

Review of Fall Risk Assessments showed that the most recent assessment prior to the four unwittnessed falls was one month prior to the falls.

During an interview with Administrator #100 they stated that HIR assessments should be done per the homes policy as well as fall risk assessments should be done, per policy, when a resident has multiple falls.

The homes failure to follow their Falls Prevention and Management policy related to completion of HIR assessments and fall risk assessments placed 3 residents at risk for falls and risk for complications resulting from falls.

Sources: Resident's clinical records, the homes Falls Prevention and Management

policy, interview with Administrator #100. [s. 8. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 :

1. The licensee has failed to ensure that a resident was free from neglect by the licensee or staff in the home.

O. Reg. 79/10, defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents”.

The home called the After Hours Reporting line on a specific date, to report the fall of a resident requiring additional medical intervention.

The home submitted a Critical Incident System report (CIS), alleging that Registered Nurse (RN) #113 had neglected the resident who had experienced a fall that resulted in an injury.

Review of the homes fall incident report stated that the fall had occurred at a specific time and date. RN #113 documented that they had assessed the resident and found that the resident had exhibited specific symptoms.

Progress notes completed by the oncoming shift stated that the resident had specific symptoms and that the resident required specific medical interventions.

During an interview with Administrator #100 and review of their investigation notes and College of Nurses of Ontario (CNO) submission, they stated that when they became aware of the resident's fall they had reviewed the camera that showed the entrance to the resident’s room and found that RN #113 had last entered the resident’s room at a specific time however they had documented assessments throughout their shift. During a subsequent meeting with the Administrator #100, RN #113 admitted to falsifying the assessment documentation and admitted they had not assessed the resident beyond the initial assessment.

The failure of RN #113 to complete specific assessments and reassess the resident post incident placed the resident at risk for complications related to the injury.

Sources: CIS report, After Hours Reporting line, review of a resident’s clinical record, review of the homes investigation notes, review of the homes submission to the CNO and interview with Administrator #100. [s. 19. (1)]

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 ensure 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 28th day of March, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : DEBRA CHURCHER (670)

Inspection No. / No de l'inspection : 2022_974670_0007

Log No. / No de registre : 018104-21, 018162-21

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Mar 28, 2022

Licensee / Titulaire de permis : Corporation of the County of Elgin
450 Sunset Drive, 3rd Floor, Suite 303, St Thomas, ON, N5R-5V1

LTC Home / Foyer de SLD : Elgin Manor
39262 Fingal Line, R.R. #1, St Thomas, ON, N5P-3S5

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Terri Benwell

To Corporation of the County of Elgin, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 r. 8.(1). (a). (b).
Specifically;
A) The licensee must ensure that the home's policy Falls Prevention and Management is implemented and complied with.
B) The licensee must ensure that all Registered Nurses and Practical Nurses receive re-training related to the home's policy.
C) The licensee must keep a record related to the training that indicates the staff members that received the training and the date the training was completed.
D) The Manager of Resident Care or delegate will complete weekly audits of two falls (if available) with a specific focus on falls requiring Head Injury Routine assessments and residents that are experiencing a change in condition or multiple falls.
E) Record and retain the record of any deficits identified in the audits and any corrective actions taken.
F) Audits are to continue for four months or until compliance is achieved as determined by a follow up inspection.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

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that the following interdisciplinary programs are developed and implemented in the home. A falls prevention and management program to reduce the incidence of falls and the risk of injury."

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Sources: Resident's clinical records, the homes Falls Prevention and Management policy, interview with Administrator #100.

An order was made taking the following factors into account:

Severity: The severity was determined to be minimal risk.

Scope: The scope was determined to be wide spread as the policy was not followed for all residents inspected.

Compliance History: The home has a compliance history of nine Voluntary Plans of Correction, thirteen Written Notifications, one Compliance order related to different subsections of the legislation and three Written Notifications and two Voluntary Plans of Correction related to the same subsection of the legislation.

(670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 20, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of March, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debra Churcher

Service Area Office /
Bureau régional de services : London Service Area Office