Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
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London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: April 29, 2025

Inspection Number: 2025-1543-0002

Inspection Type:
Critical Incident

Licensee: Corporation of the County of Elgin

Long Term Care Home and City: Elgin Manor, St Thomas

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24, 25, 28, 29, 2025
The inspection occurred offsite on the following date(s): April 28, 2025

The following intake(s) were inspected:

- Intake: #00142611 -M518-000012-25 Related to an outbreak.
- Intake: #00142976 -M518-000013-25 Related to an allegation of staff to resident abuse.
- Intake: #00144695 -M518-000021-25 Related to a fall.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to ensure that a resident was protected from abuse by a Personal Support Worker (PSW).

Sources: Investigation notes, Resident Abuse Policy 2.11 (Revised December 2024), and interviews with the Director of Homes and Seniors Services and other staff

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect was complied with when a Personal Support Worker (PSW) failed to immediately report an allegation of staff to resident abuse. The home's policy titled "Resident Abuse 2.11," (Revised December 2024) stated that in any case

of alleged or suspected abuse the employee who witnessed or had knowledge of an incident shall verbally report the abuse immediately to their direct supervisor and provide a written statement upon reporting the alleged abuse.

Sources: Critical Incident Report, Investigation Notes, Resident Abuse Policy 2.11 (Revised December 2024) and Interviews with the Director of Homes and Seniors Services and the Administrator.