



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 sous la Loi de 2007 sur les foyers de soins de longue durée

**Health System Accountability and Performance Division
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**Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|--|---|--------------------------------|--|
| Oct 4, 2013 | 2013_24304_0001 | L-000774-13 | Critical Incident System |

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ELGIN MUNICIPAL HOMES
39262 Fingal Line, RR #1, ST. THOMAS, ON, N5P-3S5

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

DEIRDRE BOYLE (504)

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): 2 October, 2013.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, one Registered Practical Nurse, three Personal Support Workers and five Residents.

During the course of the inspection, the inspector(s) reviewed the plan of care for the Resident, the medication administration record for the Resident and observed Resident care.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| Legend | Legendé |
|------------------------------------|---------------------------------------|
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | WAO – Ordres : travaux et activités |



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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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
- (a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
 - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
 - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

Findings/Faits saillants :



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1. The Licensee had not ensured the written plan of care provided clear direction to staff and others who provided direct care to the Resident.

The plan of care for an identified Resident was reviewed.

A Registered Nurse used an intervention that was not indicated in the plan of care during an interaction with a Resident who was demonstrating certain behaviours.

The plan of care did not give clear direction to staff of what interventions to follow should the Resident demonstrate these behaviours.

The Care Plan in Point Click Care was updated with new interventions after the interaction.

Three Personal Support Workers and one Registered Practical Nurse confirmed that the plan of care did not set out clear direction.

Issued on this 4th day of October, 2013

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

Deirdre Boyle