Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
Nov 15, 2018	2018_610633_0020	013586-17, 024165-17, 025762-17, 001689-18, 007121-18, 025291-18, 028182-18	Critical Incident System

Licensee/Titulaire de permis

Corporation of the City of Guelph
c/o The Elliott Long Term Care Residence 170 Metcalfe Street GUELPH ON N1E 4Y3

Long-Term Care Home/Foyer de soins de longue durée

The Elliott Long Term Care Residence
170 Metcalfe Street GUELPH ON N1E 4Y3

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

SHERRI COOK (633), MARIA MCGILL (728)

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 23, 24, 26, 2018.

The following critical incident intakes were completed during this inspection:

Log #013586-17 related to alleged abuse and responsive behaviours.
Log #024165-17, #007121-18 and #025291-18 related to falls prevention.
Log #025762-17 related to pain management and falls prevention.
Log #001689-18 related to infection control.
Log #028182-18 related to alleged abuse.

Inspectors Amanda Owen #738 and Kiyomi Kornetsky #743 were present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Restorative Care Aide, a nursing student, a private care-giver and a house keeper.

In addition, the inspector(s) observed resident/staff interactions and reviewed the plans of care for the identified residents and the home's related documentation and policies.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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 :

1. The licensee failed to protect residents from abuse by anyone.

O. Reg 79/10 s. 2 (1) defines emotional abuse as "any threatening, insulting, intimidating, or humiliating gestures, actions, behaviour, or remarks including imposed social isolation, shunning, ignoring, lack of acknowledgement, or infantilization that are performed by anyone other than the resident."

A critical incident (CI) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding an alleged incident of staff to resident abuse. The CI stated that four staff witnessed another staff member perform a gesture towards an identified resident.

The identified resident said that they did not recall the incident.

Four staff witnessed the incident and said that the incident was abuse.

The identified staff member denied that abuse had occurred.

The home's policy titled "Abuse – Definition and Prevention", last reviewed June 2018 defined this incident as abuse.

The Director of Care (DOC) said this incident was abuse. The DOC also said that the staff members who witnessed the incident had stated they were upset about having witnessed this incident.

The licensee failed to protect an identified resident from abuse by an identified staff member.

2. Another CI report was submitted to the MOHLTC regarding an incident of staff to resident abuse. The CI stated that an identified resident had symptoms during care and

an identified staff member took an improper action towards the resident. The CI also stated that the resident had increased symptoms in response.

A registered staff said that they were assisting another staff member with a specific care for the identified resident. The staff member performed a gesture and the resident was upset as a result of this incident.

The resident no longer resided at the home.

The identified staff member was unable to be contacted as part of the inspection however the home's investigative records contained a statement from the staff member. They stated that the incident occurred and they were aware that their actions were wrong.

The DOC said that the staff member admitted during their investigation that the incident occurred. The DOC also said that this incident was abuse.

The licensee failed to protect an identified resident from abuse by a staff member.

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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. 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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care of a resident and abuse of a resident by anyone that resulted in harm or risk of harm to a resident was immediately reported to the Director with the suspicion and the information upon it was based.

A CI report was submitted to the MOHLTC regarding an incident of staff to resident abuse. The CI stated that an identified resident had symptoms during care and an identified staff member took improper action towards the resident. The CI also stated that the resident had increased symptoms in response to the actions of the staff member. The CI stated that the incident occurred on a specific date, however the CI was not submitted to the Director until two days later.

The plan of care for the resident documented that the incident occurred on a specific date.

The home's investigative records documented that the identified staff member was contacted on a specific date.

The DOC said that the expectation for reporting alleged abuse of a resident was to report to the Director immediately. The DOC agreed that this incident was not submitted to the Director on time.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care and abuse of an identified resident by a staff member that resulted in harm or risk of harm to the resident was immediately reported to the Director with the suspicion and the information upon which it was based.

Issued on this 29th day of November, 2018

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

Original report signed by the inspector.