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
May 7, 2019	2019_655679_0011	007901-19	Complaint

Licensee/Titulaire de permis

Elm Grove Living Centre Inc.
35 Elm Grove Avenue TORONTO ON M6K 2J2

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

Elm Grove Living Centre
35 Elm Grove Avenue TORONTO ON M6K 2J2

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

MICHELLE BERARDI (679)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 29 to May 3, 2019.

The following intake was inspected upon during this Complaint Inspection:

- One intake submitted to the Director for a bed refusal.

A Critical Incident System (CIS) Inspection #2019_655679_0010 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Quality Care Supervisor, Social Worker, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, as well as relevant policies and procedures.

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

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. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written notice setting out a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care, and the contact information for the Director was provided when the licensee withheld approval for admission to the home.

A) Inspector #679 reviewed an admission application rejection letter that was forwarded to the Director. The rejection letter titled "Application Rejection" identified that applicant #007 had been refused admission because the home was unable to meet the applicant's care needs as the applicants identified care needs exceeded that of which the staff, environment, and resources were able to safely support.

The Application Rejection letter did not contain a detailed explanation of the supporting facts as they related to both the home and the applicants condition, nor did it contain contact information for the Director.

B) Inspector #679 reviewed an admission application rejection letter for applicant #010. The rejection letter titled "Application Rejection" identified that the home was unable to meet the applicant's care needs as their identified care needs exceeded that of which the staff, resources, and environment were able to safely support.

The Application Rejection letter did not contain a detailed explanation of the supporting facts as they related to both the home and the applicants condition, nor did it contain contact information for the Director.

C) Inspector #679 reviewed an admission application rejection letter for applicant #011. The rejection letter titled "Application Rejection" identified that the home was unable to meet the applicant's care needs as there was no specialized unit available. The letter further identified that Elm Grove could not accept this application due to the requirement for a specified safety intervention. The Application Rejection letter did not contain contact information for the Director.

In an interview with Inspector #679, Social Worker (SW) #100 identified that they receive and review the admission applications, prior to discussion with the management team. SW #100 then identified that they would reply to the applicant with the home's response based on if they were able to manage or not manage the applicant's care. Together, Inspector #679 and SW #100 reviewed the application letters for applicants #007, #010 and #011, which did not identify contact information for the Director. SW #100 further identified that the statement regarding applicant #007's identified care needs contained on the admission application rejection letter was a general statement used by the home.

In an interview with Inspector #679, the Director of Care (DOC) identified that the home's SW initially reviewed the applications, and that then the applications were reviewed in the morning report. The DOC indicated that SW #100 wrote the admission rejection letters and that they were reviewed by the DOC or the Administrator. Together, the DOC and the Inspector reviewed the Long Term Care Home's Act and the Application Rejection letter for applicant #007. The DOC identified that the Local Health Integration Network Ministry of Health fax number was present.

In an interview with the Administrator they identified that they had changed the letter to provide the contact information for the Director. [s. 44. (9)]

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 ensuring that a written notice setting out a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care and the contact information for the Director is provided when the licensee withholds approval for admission to the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that resident #009 had the right to have their participation in decision-making respected.

During the inspection, resident #009 requested to speak with a Ministry of Health and Long Term Care Home's Inspector.

In an interview with Inspector #679, resident #009 voiced concerns regarding the specified care provided by RN #112. Resident #009 identified that they were speaking to RN #112 regarding their care and that the RN did not respond appropriately. Resident #009 further identified that while RN #112 was assisting with their care they performed a specific action which caused a specified injury.

Inspector #679 reviewed a document dated a specified date, which identified that resident #009 brought their concerns forward to the DOC. The document identified that the resident brought forth their concerns regarding the care provided by RN #112. A

further review of the document identified that the DOC interviewed PSW #106 who was present during the specified care and they had identified that the resident had voiced a specific request.

In an interview with PSW #106, they explained that they were present while RN #112 completed the specified care. PSW #106 identified that the resident voiced specified concerns towards RN #112, but that RN #112 completed the care without implementing the residents request.

In an interview with RPN #107, they explained that they had requested for RN #112 to complete the specified care and that they had not witnessed the interaction. RPN #107 identified that resident #009 had mentioned the interaction to them after the occurrence and that resident #009 was upset. RPN #107 further indicated that if the resident had voiced a specified request the staff member should have followed through with the residents request.

In an interview with the Resident Quality Care Supervisor (RQCS) they identified that resident #009 reported the care which was provided to them by RN #112 after the interaction. The RQCS identified that they did not recall resident #009 indicating a specified request to RN #112, but that if they did voice the request, the staff member should have followed through with the residents request.

In an interview with the DOC, they identified that resident #009 complained about the specified care provided by RN #112. The DOC identified that they could not remember at which point of the specified care that resident #009 voiced the request. The DOC identified that if resident #009 did voice a request, the staff should have followed through with the residents request.

Issued on this 8th day of May, 2019

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

Original report signed by the inspector.