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

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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
Aug 14, 2020	2020_678590_0009	011925-20	Critical Incident System

Licensee/Titulaire de permis

Elmwood Place Operating Inc.
5015 Spectrum Way, #600 MISSISSAUGA ON L4W 0E4

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

Elmwood Place
46 Elmwood Place West LONDON ON N6J 1J2

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

ALICIA MARLATT (590)

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): July 21, 2020.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, one Registered Nurse and two Personal Support Workers.

During the course of the inspection, the inspector reviewed a Critical Incident System report, a Risk Management report and a resident clinical record.

During the course of the inspection, the inspector observed infection prevention and control practices, a resident and their room for specific interventions to be in place.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A mandatory Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care, reporting the improper or incompetent treatment of a resident that resulted in a risk of harm. The report described in short, that resident #001 had fallen from their mobility device when left unattended for a short period of time without their safety devices applied. The resident sustained only minor injuries as a result and could stay at the home to be monitored.

Review of resident #001's care plan showed a focus on the use of a Personal Assistance Service Device (PASD) to assist with activities of daily living. Another focus was on support for mobility outlining a risk for falls and identified that the resident used an identified safety device attached to their mobility device. The resident required total care from the staff.

Review of the post-fall assessment, the Risk Management report and progress note that was completed for resident #001's fall showed the same documented description of the incident completed by Registered Nurse (RN) #102 who discovered the resident on the floor. The RN wrote that the PASD function had not been applied and the safety device had also not been applied and were the contributing factors to the fall.

In an interview with RN #102 who discovered resident #001 on the floor, they shared the same description that they had documented above. They further shared that they had spoken with Personal Support Worker (PSW) #103. The PSW told them that they forgot to apply the PASD function and safety device before they left the resident unattended. The RN shared that resident #001's PASD was to be applied at all times while utilizing their mobility device for safety and comfort reasons and that this had been outlined in the resident's plan of care at the time of this fall.

In an interview with PSW #103 they shared that they had forgotten to apply the PASD and safety device before they left. They said that they had seen a call bell down the hall going off and got distracted by answering it as their partner was on break. They shared that they were aware that resident #001 needed the PASD function on their mobility device and safety device for safety purposes and was thankful that the resident was not seriously injured as a result.

In an interview with the Director of Care (DOC) they shared that this was a very unfortunate incident. They shared that resident #001's care plan had been clear about the resident requiring the PASD function while utilizing their mobility device along with

their safety device. The DOC and the Executive Director both answered yes when asked if this resident's care plan had not been followed. [s. 6. (7)]

Issued on this 14th day of August, 2020

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

Original report signed by the inspector.