



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

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

**London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685**

**Bureau régional de services de
London
291, rue King, 4^{ième} étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685**

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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



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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

WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order

Legendé

WN – Avis écrit
VPC – Plan de redressement volontaire
DR – Aiguillage au directeur
CO – Ordre de conformité
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