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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 7, 2016	2016_254610_0021	17126-16	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ELGIN MUNICIPAL HOMES
475 Talbot Street E. AYLMER ON N5H 3A5

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

TERRACE LODGE
475 TALBOT STREET EAST 49462 TALBOT LINE AYLMER ON N5H 3A5

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

NATALIE MORONEY (610)

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): June 8, 9, 2016

The purpose of this inspection was conducted related to complaint # 017126-16 for Prevention of Abuse, Neglect and Retaliation and Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Resident Care Coordinator, one Registered Practical Nurse, three Personal support workers, residents and families.

The inspector completed interviews, observed resident care areas, reviewed health care records and relevant policies and procedures and documentation.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Legendé 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 O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The Licensee failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

A review of resident # 002's documentation showed that the resident had behaviours and had identified triggers toward resident # 001.

Further review of documentation showed an intervention had been implemented to monitor and observe resident # 002 and document behaviours.

An observation period was initiated for resident # 002 to monitor behaviours. This documentation was incomplete for resident #002

The Resident Care Coordinator (RCC) # 101 on June 8, 2016 said that the documentation should have been completed during the observation period and documented to identify and implement interventions once completed.

The Manager of Resident Care (MRC) # 100 on June 9, 2016, said that observation documenation should have been completed

The licensee failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions for resident # 002. [s. 54. (b)]

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 steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The Licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Review of documentation showed that resident # 001 had a health condition and had been a trigger for behaviours from resident # 002.

The Homes Policy Responsive Behaviour Policy revised November 2015:

When an individual's responsive behaviour escalates this can lead to altercations among residents or staff and may be harmful or abusive. Therefore the key aspect of resident care is to prevent or minimize the situation in which a resident exhibits responsive behaviours……the most effective strategies for individual residents into their plan of care, and implement these strategies through a coordinated, interdisciplinary approach.

Acute Responsive Behaviour Management Screening Decision Tree assessments that may be completed; PIECES, Dementia Observation System (DOS), Cornell Scale, Cohen Mansfield agitation inventory and Pain Assessment.

In the event of resident to resident interaction resulting in injury the following will be

completed by the registered staff immediately; Update the Care Plan and Point of Care Kardex with interventions.

A review of resident # 001's documentation showed that the resident was to be monitored and documentation was to be completed and had not.

Resident # 001's plan of care was not updated to identify the causes and triggers related to behaviours with resident # 002.

Further review of resident # 001's assessment showed that there were no clinical assessments to ensure identification or causes of the responsive behaviours and there was no monitoring or implementation of interventions for resident # 001 for staff to identify safety issues when engaged with resident # 002.

The Manager of Resident Care (MRC) # 100 said that resident # 001 should have been assessed, using a clinically appropriate assessment tool and that the interventions should have been implemented and part of resident # 001's plan of care with responsive behaviours to decease the risk of harm.

The licensee failed to ensure that resident # 001 had procedures and interventions developed and implemented to minimize the risk of altercations and potentially harmful interactions with resident # 002 including heightened monitoring because those behaviours posed a potential risk to resident # 001. [s. 55. (a)]

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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 7th day of July, 2016

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

Original report signed by the inspector.