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
Nov 3, 2016	2016_243634_0020	029166-16	Resident Quality Inspection

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

ADAM CANN (634), INA REYNOLDS (524), SHERRI GROULX (519)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 20, 21, 24, 25, and 26, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Manager Support Services, the Resident Care Coordinator, two Registered Nurses, two Registered Practical Nurses, one Recreational staff member, one Maintenance worker, and eight Personal Support Workers.

The inspector (s) conducted a tour of the home, reviewed clinical records and plan of care for relevant residents, pertinent policies and procedures, Residents' and Family Council minutes and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, medication administration, and required Ministry of Health and Long Term Care postings.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to were, kept closed and locked.

During the initial tour of the home, a door at the end of the hallway on the Lower South home area was found to be unlocked. This door had a pin pad that was showing a red light, meaning it was locked, when it fact it was able to be opened by the inspector. The open door led to a stairway leading to the second floor of the home.

This was immediately reported by the inspector to the Manager of Support Services who then notified the Maintenance staff. The door was repaired and upon re-observation, it was noted to be locked.

The licensee failed to ensure that a door on Lower South home area, leading to a stairway, was kept closed and locked. [s. 9. (1) 1.]

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 all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, kept closed and locked, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the PASD described in subsection (1) that are used to assist a resident with a routine activity of living was included in the residents' plan of care.

During observations a resident was observed to have a Personal Assistive Service Device (PASD). This was observed on several subsequent observations throughout the Resident Quality Inspection (RQI). The resident was unable to remove the PASD on their own.

Record review revealed that there were no progress notes, care plan entries, or assessments regarding the use of the Personal Assistance Services Device (PASD).

Record review of the progress notes, care plan, physician orders, and assessments revealed that there was no approval for the use of the Personal Assistance Services Device (PASD) by a physician, registered nurse, registered practical nurse, occupational therapist, physiotherapist,or any other person provided for in the regulations.

Record review of the progress notes and physician orders revealed that there was no notation made regarding consent for the use of the Personal Assistance Services Device (PASD) or restraint, by the resident or the Substitute Decision Maker (SDM).

Upon interview with a Personal Support Worker (PSW), it was stated that the resident used the PASD for assistance with routine activities of daily living.

Upon interview with a Registered Practical Nurse (RPN), it was stated that resident used the PASD for assistance with routine activities of daily living.

Upon interview with the resident, it was stated that she liked the PASD and wanted to keep it so she could use it for routine activities of daily living.

Upon interview with the Manager of Resident Care, it was stated that the resident had used the PASD for some time. The Manager of Resident Care stated that it would be the home's expectation that it would have been included in the resident's plan of care. [s. 33. (3)]

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 the PASD described in subsection (1) that is used to assist a resident with a routine activity of living is included in the residents' plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff

Record review was completed of the Resident Assessment Instrument which stated that a resident had an area of altered skin integrity.

Record review was completed of the weekly skin/wound assessment sheet in the resident's physical chart. The assessment showed that the area of altered skin integrity had not been assessed weekly.

Interview was conducted with a Registered Practical Nurse who said that the expectation of the home was that a weekly skin assessment was required for a resident with altered skin integrity. The RPN said that weekly wound assessments should have been completed for resident but were not completed.

Interview was conducted with the Manager of Resident Care (MRC)who stated that the expectation of the home was that weekly skin assessments were completed for residents with altered skin integrity. The MRC said that the resident had altered skin integrity and should have had weekly skin assessments completed and they were not. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

A review of the Residents' Council meeting and Food Committee meeting minutes from October 2015 to September 2016 indicated there was no evidence to support that meal and snack times were reviewed by Residents' Council.

The Food Service Supervisor stated that the home had completed a Satisfaction Audit and Survey which included a question related to the meal service schedule but that the meal and snack times specifically were not reviewed by Residents' Council. [s. 73. (1) 2.]

Issued on this 4th day of November, 2016

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

Original report signed by the inspector.