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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2018	2018_607523_0024	028979-16, 001068-17, 001398-17, 020899-17, 023607-17, 026731-17, 027801-17, 000817-18, 001841-18, 003183-18, 005103-18, 006050-18, 007443-18, 017409-18, 023278-18, 025131-18, 025267-18	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive ST. THOMAS ON N5R 5V1

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

ALI NASSER (523), INA REYNOLDS (524)

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): September 24, 25, 26, 27,

28, October 1 and 2, 2018.

The following intakes were completed within this inspection:
Critical Incident Log #020899-17 / CI M583-000011-17 related to improper care to a resident.
Critical Incident Log #026731-17 / CI M583-000025-17 related to a resident's fall.
Critical Incident Log #001841-18 / CI M583-000004-18 related to alleged neglect of a resident.
Critical Incident Log #000817-18 / CI M583-000001-18 related to alleged neglect of a resident.
Critical Incident Log #027801-17 / CI M583-000026-17 related to a resident's fall.
Critical Incident Log #007443-18 / CI M583-000021-18 related to a resident's fall.
Critical Incident Log #028979-16 / CI M583-000021-16 related to a resident's fall.
Critical Incident Log #025131-18 / CI M583-000056-18 related to a resident's fall.
Critical Incident Log #003183-18 / CI M583-000007-18 related to alleged verbal abuse of a resident.
Critical Incident Log #017409-18 / CI M583-000041-18 related to alleged verbal abuse of a resident.
Critical Incident Log #023607-17 / CI M583-000018-17 related to alleged physical abuse of a resident.
Critical Incident Log #006050-18 / CI M583-000015-18 related to alleged verbal abuse of a resident.
Critical Incident Log #005103-18 / CI M583-000011-18 related to alleged neglect of a resident.
Critical Incident Log #023278-18 / CI M583-000049-18 related to alleged resident to resident physical abuse.
Complaint Log #001398-17 / IL-48893-LO/IL-48894-LO related to staffing shortages.
Complaint Log #025267-18 / IL-59968-LO related alleged neglect of a resident.
Complaint Log #001068-17 / IL-48848-LO related to staffing shortages.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Administrative Assistant, Resident Care Coordinator, three Registered staff members, six Personal Support Workers, eight residents and two family members.

The inspectors also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, and

reviewed the written staffing plan of the home and various meeting minutes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, was fully respected.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date. The CIS showed that a specific resident reported to a staff member that a PSW had spoken to them in an unkind manner.
A review of the home's investigation notes showed a letter from the home to the employee that included the following "The home has concluded that your conduct is in violation of the Resident's Bill of Rights".

The home submitted a CIS report to the MOHLTC on a certain date. The CIS showed that a specific resident reported to a staff member that the way a PSW spoke to them was rude and harsh.
A review of the home's investigation notes showed a letter from the home to the employee that included the following "The County has concluded that your conduct was in violation of the Resident's bill of Rights".
In an interview the DOC said that they submitted and completed the CIS. They said that the staff did not respect the resident's right by not treating and talking to them in a respectful manner.

The home submitted a CIS report to the MOHLTC on a certain date. The CIS showed that a PSW was heard talking to a specific resident in a threatening and disrespectful manner.
A review of the home's investigation notes showed a letter from the home to the employee that included the following "The County has concluded that your conduct was in violation of the Resident's Bill of Rights."
In an interview the DOC said the staff member did not respect the resident's right and spoke with them in a threatening disrespectful manner.

In an interview the Administrator said that the staff did not respect the resident's Rights. Administrator said that they disciplined the staff accordingly and they would continue to provide education and support for the employee to ensure resident's rights were protected. [s. 3. (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 the residents' right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, was fully respected, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) This inspection was initiated as a result of Critical Incident System (CIS) reports submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a certain dates, regarding a fall incidents for two specific residents.

Review of the residents' clinical records showed that the assessments for each resident were not consistent and the outcomes did not complement each other.

In an interview the Director of Care agreed that the specific assessments for the specific residents were not consistent and outcomes did not complement each other. DOC acknowledged it was the home's expectation that there would be an interdisciplinary team approach to ensure assessments were integrated, consistent and complement each other and assessment were completed in collaboration with all staff involved. [s. 6. (4) (a)]

2. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a Critical Incident System (CIS) report on certain date. The CIS showed that the resident was left unattended during a specific task. CIS also showed that Manager of Resident Care will be further investigating the incident as staff did not remain with the resident during the task.

A clinical record review, plan of care for the resident showed a direction for staff to stay with the resident during this task.

In an interview the DOC said that the staff were supposed to stay with the resident during this task but they did not. The care was not provided as set out in the plan of care.

The licensee has failed to ensure that the care set out in the resident's plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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:
staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other; and
the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, that the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

This inspection was initiated as a result of specific complaint submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a certain date, related to specific resident's concerns.

During a telephone conversation with the resident's family member it was stated that on a certain date the resident sustained a fall in the hallway and was admitted to hospital with specific injuries. The resident was deceased on a later date. The family member said that the home had informed them that the resident had a previous fall on a specific date with possible specific injury, which was not reported to the family.

Review of the resident's clinical record showed that the resident had an unwitnessed fall on a certain date. There was no documented evidence that a post-fall assessment or head to toe assessment using a clinically appropriate assessment instrument was completed by registered staff.

The Administrator reviewed the clinical record and acknowledged that the Post Fall Assessment Head to Toe assessment and risk management tools were not completed and should have been done for the resident's fall. [s. 49. (2)]

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 when a resident has fallen, that the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

A review with the DOC of the Surge Course Completion for "Policy: Admin-2.11-Resident Abuse- revised March 2017" "From: 2017-01-01 To 2018-06-01"
showed that 87 out of 97 employees completed the mandatory training.

DOC said that one of the names listed were not an employee of the home.
DOC said this report showed that 87 out 96 (90.6%) completed the training.

DOC said that this report from January 1, 2017 to June 1, 2018 showed that not all staff completed the annual training. DOC said it was the expectation of the home that all staff would complete the annual training. [s. 76. (4)]

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 staff received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

Review of the Terrace Lodge Surge Learning online education records for 2017 showed that not all staff who provided direct care to residents had received the mandatory annual training as follows:
- Falls Prevention and Management – 6 of 60 (10%).

In an interview the DOC acknowledged not all staff that provided direct care to resident had received the annual training related to Falls Prevention and Management for 2017. DOC said that the expectation was that all direct care staff were to complete the annual Falls Prevention and Management course on Surge Learning as required. [s. 221. (2) 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 staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that allowed calls to be cancelled only at the point of activation.

The home submitted a Critical Incident System (CIS) report on a certain date, the CIS showed that a specific resident informed a staff member that a specific staff member answered the call bell over the intercom.

During the inspection a specific RPN told inspector that the home's resident-staff communication and response system can be answered and deactivated through the intercom on the nursing stations and by the common area on each of the resident home areas.

During the inspection the Administrator demonstrated and observed with inspector the resident-staff communication and response system being deactivated from the common area on the LS resident care area.
Administrator informed inspector that they will be ensuring that the resident-staff communication and response system will be cancelled only at the point of activation.

on a later date during the inspection the Administrator informed inspector that an external company came in, reset and programed the resident-staff communication and response system and ensured that calls could be cancelled only at the point of activation.

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that allowed calls to be cancelled only at the point of activation. [s. 17. (1) (c)]

Issued on this 25th day of October, 2018

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

Original report signed by the inspector.