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
Sep 28, 2020	2020_777731_0016	011231-20, 012104-20, 014787-20	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive 3rd Floor, Suite 303 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

KRISTEN MURRAY (731), MEAGAN MCGREGOR (721)

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 14, 15, 16, and 17, 2020

The following Critical Incident intakes were completed within this inspection:

Related to improper care:
Critical Incident Log # 011231-20 / CI M583-000027-20

Related to falls prevention
Critical Incident Log # 012104-20 / CI M583-000029-20
Critical Incident Log # 014787-20 / CI M583-000033-20

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care (MRC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

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 home's internal investigation documentation.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 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 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. licensee has failed to ensure that three residents who had wounds, had skin assessments, were reassessed at least weekly, and were assessed by the Registered Dietitian.

Resident #001 had wounds and did not have a completed skin assessment. Weekly skin assessments for the wounds were not completed. The treatment orders did not specify which wound they referred to. Order documentation for treatment and monitoring of the wound was not completed, and there was no documented assessment by the Registered Dietitian completed.

2. Resident #002 had a wound and a skin assessment was not completed. There was no documentation when the wound had healed. Order documentation for treatment and monitoring of the wound was not completed, and there was no documented assessment by the Registered Dietitian completed.

3. Resident #003 had wounds and weekly skin assessments were not completed. Order documentation for treatment and monitoring of the wound was not completed.

There was an increased risk that the three residents' wounds would worsen with weekly skin assessments not completed, and no registered dietitian assessments.

The home's Skin Care and Wound Management policy stated registered staff were to complete a skin assessment upon finding a pressure ulcer, and complete those assessments weekly. The home's policy stated that skin tears and stasis ulcers should be documented in progress notes, and did not address that a resident who had wounds, including skin tears, should have received a skin assessment.

Sources: CIS report, Skin Care and Wound Management policy, three residents' electronic records including progress notes, skin assessments, and treatment administration records, and interviews with the Manager of Resident Care (MRC) and other staff. [s. 50. (2) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that a Personal Support Worker (PSW) used safe transferring and positioning techniques when they assisted a resident.

A PSW independently transferred a resident using a mechanical lift. The PSW did not properly reposition the equipment. The resident was assessed to require a two person transfer, however, the PSW used the lift without a second staff member present. As a result, the resident had a fall and the resident had discomfort.

The home's "Two Person Lifts and Transfers" policy stated that mechanical lifts required two people.

Sources: CIS report, Two Person Lifts and Transfers policy, resident's electronic record including progress notes and care plan, the home's investigation documentation, and interviews with the Manager of Resident Care (MRC) and other staff. [s. 36.]

Issued on this 28th day of September, 2020

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

Original report signed by the inspector.