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
Jan 27, 2021	2021_722630_0004	023504-20, 025351-20	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

AMIE GIBBS-WARD (630)

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): January 20 and 21, 2021.

The following Follow-up intake was completed within this inspection:
Log #023504-20 for Compliance Order (CO) #001 from Inspection #2020_777731_0025 related to weekly skin and wound care assessments.

The following Critical Incident (CI) intake was completed within this inspection:
Log #025351-20 / CI M583-000051-20 related to a COVID-19 Outbreak.

During the course of the inspection, the inspector(s) spoke with the Director of Homes and Seniors Services, the Administrator, the Manager of Resident Care (MRC)/Infection Prevention and Control (IPAC) Program Lead, the Manager of Environmental Services, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Dietary Aide (DA) and residents.

The inspector also observed resident rooms and common areas, observed meal service, observed IPAC practices within the home, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed COVID-19 Directive #3 and Directive #5 for Long-Term Care Homes and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #001	2020_777731_0025	630

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 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 :

1. The licensee has failed to ensure that the plan of care, including the infection prevention and control (IPAC) precaution signs on the residents' bedroom doors, provided clear direction to staff regarding the care the residents required.

There was contact and droplet precaution signs on the bedroom doors for four residents who were living in areas of the home which were not considered to be in COVID-19 Outbreak. These signs indicated that staff were required to wear masks, gloves, gowns and eye protection when providing direct care to the residents. Staff were observed entering and exiting one of the resident's room without the PPE identified on the precaution signs and the resident was taken out of their room by staff to have lunch in the hallway with other residents in the area. When staff were asked what precautions were in place for this resident and what type of personal protective equipment (PPE) they were required to wear when caring for this resident, the staff said they were not sure as they did not know why the sign was outside the room.

The Manager of Resident Care (MRC) / IPAC Lead for the home said the signage posted on residents' doors was one of the ways the staff would know what IPAC precautions were required when providing care to the residents. They said the precaution signs for these residents were incorrect as they should have been removed after previous symptoms had resolved and/or COVID-19 outbreak measures were cleared. They said there was a risk associated with having incorrect IPAC precautions signs posted on resident doors as it could be confusing to staff and negatively impact their use of correct PPE.

Sources: Observations January 20 and 21, 2021; clinical records for residents; Critical Incident System (CIS) COVID-19 Outbreak report; and interviews with a Registered Practical Nurse (RPN) and other staff. [s. 6. (1) (c)]

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 plan of care, including the infection prevention and control (IPAC) precaution signs on the residents' bedroom doors, provide clear direction to staff regarding the care the residents require, to be implemented voluntarily.

Issued on this 1st day of February, 2021

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

Original report signed by the inspector.