

**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**London Service Area Office
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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
Jul 5, 2021	2021_778563_0012	004812-21, 006706-21, 006755-21, 007965-21, 007966-21, 008466-21, 008699-21, 009019-21, 009337-21, 010018-21	Critical Incident System

Licensee/Titulaire de permisCorporation of the County of Elgin
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**

MELANIE NORTHEY (563), RHONDA KUKOLY (213)

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): June 23, 24, 25, 28 and 29, 2021**

The following Critical Incident (CI) intakes were completed within this inspection:

Log #010018-21 / CI #M583-000032-21 related to resident to resident suspected abuse

Log #009337-21 / CI #M583-000030-21 related to resident to resident suspected abuse

Log #009019-21 / CI #M583-000028-21 related to resident to resident suspected abuse

Log #008699-21 / CI #M583-000027-21 related to resident to resident suspected abuse

Log #008466-21 / CI #M583-000026-21 related to resident to resident suspected abuse

Log #007966-21 / CI #M583-000023-21 related to resident to resident suspected abuse

Log #007965-21 / CI #M583-000022-21 related to resident to resident suspected abuse

Log #006755-21 / CI #M583-000016-21 related to resident to resident suspected abuse

Log #006706-21 / CI #M583-000015-21 related to resident to resident suspected abuse

Log #004812-21 / CI #M583-000012-21 related to fall prevention

The following Complaint and CI intakes were completed as onsite inquiries within this inspection:

Log #008797-21 / IL-90788-LO related to the Infection Prevention and Control Program

Log #006148-21 / IL-89486-LO related to minimizing of restraining

Log #006847-21 / CI #M583-000018-21 related to a missing controlled substance

Log #009847-21 / CI #M583-000031-21 related to staff to resident suspected abuse

During the course of the inspection, the inspector(s) spoke with the Director of Home and Senior Services, the Administrator, the Manager of Resident Care, the Manager of Support Services, Building Maintenance, the Resident Care Coordinator / Behavioural Supports Ontario (BSO) Lead, a Housekeeper, Registered Practical Nurses, Personal Support Workers, family members and residents.

The inspector(s) conducted a tour of the home and made observations of residents and care. The inspector(s) also observed the electronic monitoring system for air

temperature, meal and snack service, resident/staff interactions, infection prevention and control practices and active visitor screening. Relevant clinical records, policies and procedures were also reviewed.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Safe and Secure Home

During the course of this inspection, Non-Compliances were not issued.

0 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

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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.

Issued on this 5th day of July, 2021

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

Original report signed by the inspector.