Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: December 6, 2022	
Inspection Number: 2022-1588-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Corporation of the County of Elgin	
Long Term Care Home and City: Terrace Lodge, Aylmer	
Lead Inspector Ina Reynolds (524)	**Inspector Digital Signature**
Additional Inspector(s) Tatiana Pyper (733564)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 28, 29, 30 and December 1, 2022.

The following intake(s) were inspected:

- Intake #00001061 [CI M583-000027-22], Intake #00001856 [CI M583-000029-22] and Intake #00002870 [CI M583-000020-22] were related to Responsive Behaviours and Prevention of Abuse;
- Intake #00002139 [CI M583-000023-22], Intake #00004773 [CI M583-000018-22], Intake #00007838 [CI M583-000036-22] and Intake #00013376 [CI M583-000042-22] were related to Falls Prevention and Management;
- Intake #00008845 was related to staffing concerns.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with the Falls Prevention and Management Program in the home for the Head Injury Routine (HIR) for a resident.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee was required to ensure the Falls Prevention and Management program was complied with, as part of the licensee's Falls Prevention and Management Program. Specifically, staff did not comply with the licensee's Managing a Fall Post Fall Assessment and Management Algorithm, reviewed February 2022, which was part of the licensee's Falls Prevention and Management Program.

Rationale and Summary

A resident had multiple unwitnessed falls requiring a Head Injury Routine (HIR) assessment. The HIR documentation was not completed for one or more of the indicated times as required; the documentation indicated "sleeping."

A resident had multiple unwitnessed falls requiring a HIR assessment. The HIR documentation was not completed for several of the indicated times as required; the documentation indicated "sleeping", or sections of the assessment were incomplete.

A resident had an unwitnessed fall requiring a HIR assessment. The HIR documentation was not completed for several of the indicated times as required; the documentation indicated "missed."

The Falls Lead indicated that the HIR for the resident was not completed according to the home's Falls Prevention and Management policy. There was potential risk to the resident when they were not neurologically assessed after having unwitnessed falls.

Sources: Critical Incident System intakes; review of a resident's clinical records, review of Terrace Lodge's Managing a Fall Post Fall Assessment and Management Algorithm, reviewed February 2022, and interview with the Falls Lead.