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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: December 19, 2023	
Inspection Number: 2023-1588-0007	
Inspection Type: Proactive Compliance Inspection	
Licensee: Corporation of the County of Elgin	
Long Term Care Home and City: Terrace Lodge, Aylmer	
Lead Inspector Rhonda Kukoly (213)	**Inspector Digital Signature** Rhonda Kukoly Digitally signed by Rhonda Kukoly Date: 2023.12.21 13:51:55 -05'00'
Additional Inspector(s) Melanie Northey (563)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5, 6, 7, 11, 12, 13, 2023.

The following intake(s) were inspected:

- Intake: #00102910 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure communication of the seven-day and daily menus.

Rationale and Summary:
The daily menu was blank, while the seven-day menu was not accessible on two dates during the inspection. The Support Services Manager (SSM) said that the expectation was for the daily menu to be written on the daily menu board for each meal and would follow up with the dietary staff who's responsibility it was to post the menu.

On December 13, 2023, the lunch menu was posted on the daily menu board and the SSM said that they obtained boards for the daily menus to be posted on all units.

Sources: Observations and staff interviews. [213]

Date Remedy Implemented: December 13, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

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

Rationale and Summary:
A resident's care plan included specific directions for safety related to toileting. Two staff individually explained the resident's toileting routine, which did not include the specific directions in the care plan, and that this routine was not new. The resident was at increased risk injury when care was not provided as per the care plan.

Sources: A resident's clinical record, and staff interviews. [563]

WRITTEN NOTIFICATION: General requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that the program evaluations for the falls prevention, skin and wound management and pain management programs, included documentation of the summary of the changes made and the date changes were implemented.

Rationale and Summary:
The falls prevention, skin and wound management, and pain management program

evaluations completed December 13, 2022, included goals indicators and new strategies to improve results, but did not include any information in the columns baseline, target, or results. There was no documentation of changes made or dates. It was unclear if any new strategies to improve results were implemented or not.

Sources: Pain Management, Falls Prevention, and Skin and Wound Management Program Evaluations completed December 13, 2022, and staff interview. [213]

WRITTEN NOTIFICATION: Dining and snack service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that the dining and snack service included food and fluids being served at a temperature that was safe and palatable to residents.

Rationale and Summary:
Two residents said that food, especially hot cereal and soup, was often served cold. They said that food was served in their dining room from and after the main dining room on their unit. They said staff brought their food down the hall to their dining room on uncovered plates, and by the time it got to them, it was cold.

On one unit, during a breakfast meal, there was a tray with several bowls of hot cereal on it, and another tray on top of the cereal. The tray of cereal sat on the

counter in the dining room for 15 to 20 minutes before it was served to residents. The main breakfast entre of toast and eggs was served by staff who walked, holding two to three plates at a time, from the steam table down the hall to the dining room, with the plates uncovered. On that unit, temperatures of food prior to service were not documented for 30 out of 42 meals over a two week period.

The Administrator and the Support Services Manager said that the expectation was that staff covered plates when delivering food, took temperatures and documented them prior to serving, and that hot cereals should not have been sitting on the counter prior to being served to residents.

Sources: Observations of meals, staff and resident interviews, Food Temperatures policy #2.17 and Meal Service policy #2.18, revised November 2022. [213]

WRITTEN NOTIFICATION: Dining and snack service

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee has failed to ensure course by course service of meals.

Rationale and Summary:
On two dates during lunch meals, staff served dessert to residents immediately following serving the entre, while residents had just started or were still eating the

entre. A Personal Support Worker, a Cook and the Support Services Manager said that the expectation was that meals were served course by course and that residents should be finished their entre and the plate cleared before serving dessert.

Sources: Observations of lunch meals, Meal Service policy #2.18, revised November 2022, and staff interviews. [213]

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (3) (c)
Quarterly evaluation
s. 124 (3) The quarterly evaluation of the medication management system must include at least,
(c) identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 246/22, s. 124 (3); O. Reg. 66/23, s. 25 (1).

The licensee has failed to ensure that a quarterly evaluation of the medication management system included identifying changes to improve the system in accordance with evidence-based practices.

Rationale & Summary
The Professional Advisory Committee (PAC)/Quality Improvement (QI) Meeting Report dated October 18, 2023, was the most recent quarterly evaluation of the medication management system. There was no documentation as part of the evaluation that included identifying changes to improve the system.

Sources: PAC/QI Meeting Report, Medication Management System Audit Summary, and Medication Incident/Near Miss Summary Report July-Sept 2023; and staff interview. [563]

WRITTEN NOTIFICATION: Annual Evaluation - Medication Management System

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 125 (1)
Annual evaluation
s. 125 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee has failed to ensure that the required members of the interdisciplinary team met annually to evaluate the effectiveness of the medication management system and to recommend any changes necessary to improve the system.

Rationale & Summary
The Medication Management and Safety Program Evaluation 2022-2023 was the most recent evaluation completed and there were multiple areas of missing documentation. The “New strategies to improve results” did not identify that the changes were implemented, documentation was “will be” and there was no clear review of the quarterly evaluations in the previous year. Where the evaluation had a space for documentation for, “Based on the results of the program evaluation described above, the following changes will be implemented in order to

improve/maintain resident outcomes" there was no documentation.

Sources: Medication Management and Safety Program Evaluation 2022-2023 and staff interview. [563]

WRITTEN NOTIFICATION: Quarterly Evaluation - Medication Incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3)
Medication incidents and adverse drug reactions
s. 147 (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon that have occurred in the home since the time of the last review in order to,
(i) reduce and prevent medication incidents and adverse drug reactions,
(ii) improve the use of glucagon and to improve the care and treatment of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and
(iii) identify patterns of incidents of severe hypoglycemia and incidents of unresponsive hypoglycemia;
(b) any changes and improvements identified in the review are implemented; and
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents that have occurred since the last review and a written record

contained all of the required information.

Rationale & Summary
The Professional Advisory Committee (PAC)/Quality Improvement Meeting Report dated October 18, 2023, included the review of medication incidents and adverse drug reactions. The report was compared to the individual medication incident reports and the dates for multiple incidents were incorrect as part of the summary. There was no written record kept of any changes and improvements identified and whether they were implemented, and there was no evaluation of the medication incidents specific to trending and analysis to determine what the home needed to change or improve to reduce and prevent medication incidents and adverse drug reactions.

Sources: PAC/QI Meeting Report and the Medication Incident/Near Miss Summary Report July-Sept 2023, and staff interview. [563]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The licensee has failed to prepare a report on the continuous quality improvement initiative for the home for the current fiscal year and did not publish a copy of the

report on its website.

Rationale and Summary

The administrator confirmed that the last quality improvement (QI) report posted on the home's website was the interim report for the 2022-2023 fiscal year and there was no report for the current fiscal year. They completed and posted a Health Quality Ontario Quality Improvement Plan report, but it did not meet all of the requirements of O. Reg. s. 168 (2).

Sources: Staff interviews, Continuous Quality Improvement Initiative policies and Quality Improvement Initiative Interim Report posted on the home's website and the Health Quality Ontario Quality Improvement Plan report for the home. [213]