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: February 22, 2024

Inspection Number: 2024-1588-0001

Inspection Type:
Critical Incident

Licensee: Corporation of the County of Elgin

Long Term Care Home and City: Terrace Lodge, Aylmer

Lead Inspector	**Inspector Digital Signature**
Debbie Warpula (577)	Debbie L Warpula Digitally signed by Debbie L Warpula Date: 2024.03.05 13:40:43 -05'00'

Additional Inspector(s)
Loma Puckerin (705241)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12-16, 20 and 21, 2024.

The following intake(s) were inspected:

- Intake: #00099065 - M583-000074-23 related to resident to resident abuse;
- Intake: #00099472 - M583-000076-23 related to alleged staff to resident abuse;
- Intake: #00103047 - M583-000081-23 related to resident fall with injury;
- Intake: #00105056 - M583-000087-23 related to resident to resident abuse; and
- Intake: #00108124 - M583-000011-24 related to resident to resident abuse.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that a resident's right to care and services consistent with their needs was fully respected and promoted when they experienced pain.

Rationale and Summary:
A Critical Incident System (CIS) report was received by the Director that alleged staff

to resident physical abuse.

In an interview with a Registered Nurse (RN) they advised that a resident had complained of pain and they had not addressed the resident's pain needs.

During an interview with the Director of Care (DOC), they advised that the resident had significant pain, their right for quality care related to their pain needs were not met when the RN failed to assess the resident's pain and had not offered pain medication.

The RN not assessing the resident's pain and not administering an as needed (prn) pain medication put the resident at actual risk.

Sources: review of CIS report, review of a resident's medical records, review of the home's investigation notes, review of the home's policy "Pain Management" and interviews with an RN and the DOC.
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WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The licensee has failed to ensure that a post-fall assessment using a clinically appropriate assessment instrument was utilized when a resident had fallen.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure the home's falls prevention and management program was in place, and ensure it was complied with.

Specifically, staff did not comply with the licensee's Head Injury Routine (HIR) policy and Fall Management policy which was part of the licensee's Falls Prevention and Management Program.

Rationale and Summary:
A CIS report was received by the Director which indicated that a resident had an unwitnessed fall and required medical care for an injury.

During a review of the resident's records, Inspector #577 noted that a particular monitoring record was not initiated and there was not a record of vital signs initiated post fall.

In an interview with Resident Care Coordinator/Falls Lead, they confirmed that as part of the home's post fall assessment, there should have been vital signs initiated and documented, and a particular monitoring record should have been initiated.

During an interview with the DOC, they advised that as part of the post fall assessment, vital signs and a particular monitoring record should have been initiated.

The home not initiating a particular monitoring record put the resident at risk as they failed to assess their neurological status as required.

Sources: review of CIS report, review of a resident's progress notes, review of the home's policy "Falls Prevention and Management", an interview with Resident Care Coordinator/Falls Lead and the DOC.

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WRITTEN NOTIFICATION: Pain

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident complained of pain, they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary:
A CIS report was received by the Director that alleged staff to resident abuse.

A review of the home's investigation notes indicated that during a particular shift, a resident complained of pain during care.

During a record review, Inspector #577 found a pain assessment completed on admission. The assessment indicated that the resident had an increase in pain when they experienced pressure to a specific area of their body, and there were specific interventions to alleviate pain.

During an interview with an RN, they advised that during their shift, a resident had complained of pain. They confirmed that they had not completed proper follow up for pain management, they had not administered pain medication and had not completed a pain assessment.

During an interview with the DOC, they indicated that an RN failed to assess a resident's pain, they had not completed a pain assessment and had not looked at the resident's Electronic Medical Records (EMAR) for prn pain medication.

An RN not assessing a resident's pain, not administering a prn pain medication and not completing a pain assessment put the resident at actual risk.

Sources: review of CIS report, review of a resident's medical records, review of the home's investigation notes, review of the home's policy "Pain Management", and interviews with a RN and the DOC.

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