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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Public Report

Report Issue Date: June 16, 2025

Inspection Number: 2025-1588-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Corporation of the County of Elgin

Long Term Care Home and City: Terrace Lodge, Aylmer

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 11, 12, 13, 16, 2025

The following intake(s) were inspected:

- Intake: #00148336 - Critical Incident System (CIS) report #M583-000022-25 concerning a resident fall with injury
- Intake: #00148555 - complaint concerning alleged improper care of a resident after a fall with a fracture and lack of palliative care

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

Responsive Behaviours
Palliative Care
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 # remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident

The licensee failed to ensure that the written plan of care provided clear direction to staff regarding falls prevention interventions for a resident.

During observations, the Inspector observed a resident sitting in their wheelchair without an assistive aid.

The care plan, revised on the same day, included generic interventions without specifying the actual devices in use or their placement.

In an interview, an RPN acknowledged that the care plan had not reflected the resident's current falls prevention needs.

The Quality Initiative and Education Consultant also confirmed that the intervention was not tailored to the resident's existing requirements and they said they would review and update the care plan accordingly.

The following day, the inspector observed the resident with the assistive aid

attached and the care plan had been revised to reflect the resident's current falls prevention interventions.

Sources: Direct observation, care plan review, and staff interviews.

Date Remedy Implemented: June 12, 2025

WRITTEN NOTIFICATION: Palliative Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 61 (4)
Palliative care
s. 61 (4) The licensee shall ensure that, based on the assessment of the resident's palliative care needs, the palliative care options made available to the resident include, at a minimum,
(a) quality of life improvements;
(b) symptom management;
(c) psychosocial support; and
(d) end-of-life care, if appropriate.

The licensee has failed to ensure a resident's palliative care needs were assessed and end-of-care options including quality-of-life improvements, symptom management and psychosocial support were available.

A review of the home's Palliative Care policies indicated that specific assessments were to be completed when a resident had a significant change in status. It further indicated that these assessments determined the resident's palliative care requirements, plan of care and symptom interventions. A review of the resident's electronic records indicated that these assessments were not completed when the resident had a significant change in condition.

There was a physician order to initiate Palliative orders and a further record review indicated that two days later the Palliative orders were initiated.

In an interview with the Administrator, they confirmed that the resident's specific assessments were not completed when the resident had a significant change in condition. They said that the Palliative orders should have been initiated when the resident had experienced ongoing decline.

Sources: review of a complaint log, a resident's progress notes, specific assessments, the residents care plan, the home's policies "Palliative Performance Scale" and "Palliative and End-of-Life Care" and interviews a Registered Nurse and the Administrator.