Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 18, 2015	2015_261522_0006	L-001984-15	Resident Quality Inspection

Licensee/Titulaire de permis

MIDDLESEX TERRACE LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

Long-Term Care Home/Foyer de soins de longue durée

MIDDLESEX TERRACE
2094 GIDEON DRIVE R.R. #1 DELAWARE ON N0L 1E0

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

JULIE LAMPMAN (522), CHRISTINE MCCARTHY (588), JOAN WOODLEY (172)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 4, 5, 6, 9, 10, 11 and 12, 2015.

During the RQI three Critical Incident inspections were completed concurrently - 1030-000003-15, 1030-000009-15 and 1030-000011-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Nurse Manager, Director of Life Enrichment, Nutrition Manager, Building Services Supervisor, three Registered Nurses, five Registered Practical Nurses, five Personal Support Workers, a Building Services Housecleaner, a Dietary Staff member, three Family Members and forty residents.

The Inspectors toured all resident home areas, the medication room, observed dining service, medication pass, provision of resident care, recreational activities, staff/resident interactions, infection prevention and control practices, reviewed resident clinical records, posting of required information and relevant policies and procedures, as well as minutes of meetings pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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	Legendé 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.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated with evidence based practices to minimize the risk to the resident.

Observation of a specific resident revealed the resident used one full side rail while in bed. Review of the resident's clinical record revealed the resident received a bed rail assessment on a specified date. Review of the assessment revealed the majority of questions were left incomplete.

Observation of a specific resident revealed the resident used two half side rails while in bed. Review of the resident's clinical record revealed the resident received a bed rail assessment on a specified date. Review of the assessment revealed the majority of questions were left incomplete.

Observation a specific resident revealed the resident used two half side rails while in bed. Review of the resident's clinical record revealed the absence of a bed rail assessment.

Interview with a Registered Staff confirmed the absence of an assessment for the use of bed rails for one resident and incomplete assessments for the other residents. The Registered Staff confirmed a complete bed rail assessment should be documented for all residents.

Interview with the Administrator confirmed the home's expectation that all residents have

an assessment for the use of bed rails completed. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident observations revealed the mattresses for three residents slid easily on the bed frame.

Review of the Home's Bed Entrapment Inspection Sheet dated February 11, 2015 revealed the following:

a) A specified resident's bed system failed zones 2, 3, 4, 6 and 7.
b) A specified resident's bed system failed zone 6.
c) A specified resident's bed system failed zones 2, 3, 4 and 7.

Further review of the Bed Entrapment Inspection Sheet revealed 54/107 (50%) of beds assessed received a failure rating in at least one zone between zone 1 and 6. Of the beds assessed 21/107 (20%) of the beds were not assessed for zone 6. This was confirmed by the staff member who completed the assessments.

Review of actions taken on the Bed Entrapment Inspection Sheet revealed corrective action was taken for three bed systems and a new bed system and a new mattress were ordered. There was no documentation to support corrective action was taken for the remainder of bed systems that failed.

Interview with the Administrator confirmed the expectation that all zones of entrapment should be assessed. The Administrator confirmed that not all bed systems passed the bed entrapment assessment and that one mattress a month will be replaced and bed systems will be replaced as capital allows; no interim measures are in place until such time that the mattress or bed system can be replaced. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences.

Observation of the medication pass on a specified date revealed the Registered Staff administered medication to a specific resident at the nurses station. The specific medication should have been administered in a private location.

Interview with the Administrator regarding the resident revealed that according to the Registered Staff, the resident does not like receiving the medication in his/her room. The resident prefers to have the medication administered at the nurses station. The Administrator confirmed the resident may refuse the medication if his/her preferences are not respected.

Review of the resident's Care Plan revealed no reference to the resident's preferences related to the resident's wish not to receive the medication in his/her room. The care plan also did not include that the resident may refuse the medication as a result of not having his/her preferences respected.

Interview with the Nurse Manager confirmed the Plan of Care did not include the resident's preferences not to receive the medication in his/her room. The Nurse Manager verified it would be the home's expectation that these preferences be care planned. [s. 6. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more that 15 centimeters.

Observation of two small lower windows in the first floor sitting room revealed the windows had the ability to open greater than 15 centimeters.

A Personal Support Worker confirmed the windows were able to open beyond 15 centimeters.

Interview with the Building Services Supervisor confirmed the windows opened beyond 15 centimeters. The Building Services Supervisor fixed the two lower windows immediately by placing stoppers on the ledges. [s. 16.]

2. Observation of the center window to the left of the emergency exit in the south basement/first floor dining room revealed the window had the ability to open greater than 15 centimeters and had no screen present. This was confirmed by a Dietary Staff Member.

Interview with the Building Services Supervisor (BSS) confirmed the window opened greater than 15 centimeters and stated the window would be fixed immediately.

The Building Services Supervisor confirmed the homes expectation that windows accessible to residents do not open more than 15 centimeters. [s. 16.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Observation of a specified resident's bed system revealed an assistive device was not applied as per the manufacturer's instructions.

Interview with the Director of Nursing (DON) confirmed the assistive device was not applied as per the manufacturer's instructions.

Interview with the Administrator confirmed the homes expectation that staff ensure the assistive device is applied as per the manufacturer's instructions. [s. 23.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Observation of medication administration revealed the Registered Staff did not wash his/her hands between residents. The Registered Staff provided keys to another Registered Staff and then administered a medication to a resident without washing his/her hands, even though hand sanitizer was located on the side of the medication cart.

The Administrator verified with the Registered Staff that the staff did not sanitize his/her hands in this situation.

Interview with the Administrator confirmed the home's expectation that hand washing or sanitizing would be done by all staff during medication administration. [s. 229. (4)]

2. Observation of a second floor communal bathroom revealed an unlocked cupboard attached to the wall. The cupboard contained unlabeled personal care items including a toothbrush, toothpaste and deodorant. This was confirmed by a Personal Support Worker.

The Personal Support Worker confirmed it is the home's expectation that all personal care items will be labelled. [s. 229. (4)]

3. Observation of a shared resident bathroom revealed an assistive device stored on the bathroom floor.

Interview with a Personal Support Worker confirmed the assistive device should not be stored on the floor.

Interview with the Administrator confirmed that all staff participate in the infection prevention and control program. [s. 229. (4)]

Issued on this 25th day of March, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522), CHRISTINE MCCARTHY (588), JOAN WOODLEY (172)
Inspection No. / No de l'inspection :	2015_261522_0006
Log No. / Registre no:	L-001984-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 18, 2015
Licensee / Titulaire de permis :	MIDDLESEX TERRACE LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	MIDDLESEX TERRACE 2094 GIDEON DRIVE, R.R. #1, DELAWARE, ON, N0L-1E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jen Shkilnyk

To MIDDLESEX TERRACE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with O.Reg. 79/10, s.15 (1)(b) to ensure that where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The plan must include the evaluation date for the beds that did not have zone 6 assessed. The plan must include the corrective action implemented for bed systems that failed the bed entrapment assessment; including three identified bed systems .

Please submit the plan, in writing, to Julie Lampman, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London, ON N6A 5R2, by email at julie.lampman@ontario.ca, by April 1, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident observations revealed the mattresses for three specific residents slid easily on the bed frame.

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(522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

Service Area Office /
Bureau régional de services : London Service Area Office