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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 4, 2018	2018_538144_0025	002004-18	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

CAROLEE MILLINER (144), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 10, 11, 12, 13, 14, 2018.

The following intakes were completed within the RQI:
Intake 023963-17, Critical Incident 1030-000022-17 related to prevention of abuse and neglect
Intake 025443-17, Critical Incident 1030-000024-17 related to the plan of care
Intake 029042-17, Critical Incident 1030-000026-17 related to alleged staff to resident abuse

Intake 029043-17, Critical incident 1030-000027-17 related to alleged staff to resident abuse
Intake 003485-18 Critical Incident 1030-000003-18 related to alleged staff to resident abuse
Intake 004403-18, Critical Incident 1030-000004-18 related to alleged staff to resident abuse
Intake 007637-18, Critical Incident 1030-000006-18 related to respiratory outbreak
Intake 009649-18, Critical Incident 1030-000008-18 related to falls prevention and management
Intake 010643-18, Critical Incident 1030-000009-18 related to falls prevention and management
Intake 016746-18, Critical Incident 1030-000011-18 related to falls prevention and management
Intake 017011-18, Critical Incident 1030-000012-18 related to alleged staff to resident abuse
Intake 015798-18, Critical Incident 1030-000014-18 related to altercations and other interactions
Intake 017351-18, Critical Incident 1030-000015-18 related to protection from certain restraining
Intake 025469-18, Critical Incident 1030-000023-17 related to environmental hazard
Intake 001162-18, Complaint Inquiry related to transferring and positioning techniques

During the course of the inspection, the inspector(s) spoke with more than twenty residents, the Residents' Council President, six family members, the Executive Director, Director of Clinical Services, Resident Assessment Instrument Coordinator, Physiotherapist, two Registered Nurses, seven Registered Practical nurses, four Personal Support Workers and one Housekeeping Aide.

During the course of the inspection, the inspectors toured all resident home areas, observed the general maintenance and cleanliness of the home, medications rooms, medication administration, the provision of resident care, recreational activities, staff to resident interactions, infection prevention and control practices and reviewed resident clinical records, relevant policies and procedures and observed the posting of required information.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a written policy to promote

zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

Ontario Regulation 79/10 defines "emotional abuse" as (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or
(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences".

Ontario Regulation 79/10 defines "physical abuse" as
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or (c) the use of physical force by a resident that causes physical injury to another resident".

A review of the homes policy #A-1.0 "Resident Abuse" last reviewed June 2010, stated in part that:
Both witnessed and suspected abuse incidents will be immediately reported to the Registered Staff member.
The Registered staff member must immediately contact the Administrator, Director of Nursing or delegate.

One Critical Incident (CI) related to alleged resident to resident abuse was reviewed.

During review of one resident's progress notes related to abuse toward a second resident, it was further noted that the resident had also abused a third resident.
This incident was not immediately reported to a manager.

The Internal BSO Referral for the resident exhibiting the abusive behavior identified three incidents within a specified period of time.

A second CI report was reviewed related to alleged abuse.

The DOC documented on the CI that the incident was not immediately reported to the on-call manager. The DOC discovered that a PSW had allegedly abused a resident.

The DOC, Physiotherapist and housekeeper stated that they would report suspected or alleged abuse of a resident to their manager.

The Administrator and RPN-Manager read the resident's progress notes related to the incident and agreed it was abuse and that staff should have complied immediately with the requirement to report suspected or alleged abuse to their supervisor. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is in place a written policy is in place to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of the home's quarterly medication review consisted of nine administration errors and five omissions errors.

The last medication error that reached one resident was discovered during a pharmacy review.

The pharmacy review included that the medication was ordered to be administered at bedtime and was given at 1538 hours.

A review of the physician's order for the resident stated that the medication was to be administered at bedtime.

A review of the resident's progress notes stated in part that the medication was administered at 1538 hours.

A review of the home’s policy # 3-6 “The Medication Pass” revised January 2018, stated, in part, “ The right resident receives the right medication (not expired) of the right dose, at the right time, by the right route for the right reason and completed the right documentation”.

During interviews, the DOC, one RN and one RPN stated that medications should be administered to residents as prescribed by the physician. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 9th day of October, 2018

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

Original report signed by the inspector.