Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2020	2020_609569_0009	003696-20, 006020-20, 011433-20, 011441-20, 016026-20	Critical Incident System

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

DONNA TIERNEY (569), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 19, 20 and September 8, 9, 10, 11, 2020.

The following intakes were completed during this inspection:
Intake log #003696-20 / Critical Incident #1030-000009-20 related to abuse/neglect;
Intake log #006020-20 / Critical Incident #1030-000017-20 related to a fall;
Intake log #016026-20 / Critical Incident #1030-000024-20 related to a fall;
Intake log #011433-20 / Critical Incident #1030-000020-20 related to a medication incident;
Intake log #011441-20 / Critical Incident #1030-000021-20 related to a medication incident.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Clinical Services, Associate Director of Clinical Services, Registered Nurses and Registered Practical Nurses, a Physiotherapist, Personal Support Workers and residents.
Observations were made of residents as well as staff to resident interactions, and relevant clinical records and reports for identified residents were reviewed, as well as relevant home policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	Légende 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that allegations of resident abuse towards several unknown residents were immediately reported to the Director.

The Executive Director (ED) of the home received an email from a source reporting they witnessed forms of abuse occurring by a home staff towards several residents during a shift they had just finished working. No resident names were identified in the email. Three days after learning of the abuse allegations, the home submitted a report to the Ministry of Long-Term Care (MLTC).

The ED said during an interview that because no residents were identified in the email, a report to the Director was not initiated until the home was able to find out who the residents were, which was discovered three days later through the home's investigative process. The ED also verified that no call was made to the MLTC after hours pager regarding the abuse allegations when the home became aware of them.

Sources: Interviews with Executive Director and the source reporting the abuse allegations; related Critical Incident report to the Director; emails. [s. 24. (1) 2.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of a medication adverse drug reaction in respect of which a resident was taken to hospital, no later than one business day after the occurrence of the incident.

On a specific month in 2020, the home submitted a Critical Incident (CI) report to the Ministry of Long-term Care (MLTC) related to a medication adverse reaction for a resident who was taken to hospital the previous month.

During an interview, the Executive Director (ED) stated that the medication incident with the resident was an adverse reaction, the resident was sent to the hospital and the incident was not reported within one business day to the Director as it should have been.

Sources: CI report to the MLTC; Resident clinical records; interview with ED. [s. 107. (3) 5.]

Issued on this 24th day of September, 2020

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

Original report signed by the inspector.