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 sions de longue durée

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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 16, 2016	2016_254610_0006	002282-16	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

NATALIE MORONEY (610), MELANIE NORTHEY (563), REBECCA DEWITTE (521)

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): February 16, 17, 18, 19, 23, 24, 25, 26, 29 and March 1, 2016.

The following Critical Incidents and Complaint were conducted concurrently during the Resident Quality Inspection
This Complaint #019275-15/IL-39743 was related to personal support services and medications.
This Critical Incident #024642-15/000260-15/1030-000021-15/1030-000029-15 was related to prevention of abuse, neglect, and retaliation
This Critical Incident #027610-15/1030-000023-15 was related to prevention of abuse, neglect, and retaliation
This Critical Incident #003061-16/1030-000003-16 was related to prevention of abuse, neglect, and retaliation
This Critical Incident #031187-15/1030-000025-15 was related to dignity, choice and privacy and prevention of abuse, neglect, and retaliation
This Critical Incident #034406-15/1030-000027-15 was related to medication
This Critical Incident #034950-15/1030-000028-15 was related to prevention of abuse, neglect, and retaliation
This Critical Incident #035419-15/1030-000030-15 was related to prevention of abuse, neglect, and retaliation
This Critical Incident #021600-15/1030-000018-15 was related to prevention of abuse, neglect, and retaliation

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, one Nurse Manager, one Minimal Data Set Nurse, one Nutrition Manager, one Environmental Manager, one Life Enrichment Manager, one housekeeper, eleven Personal Support Workers, nine Registered Practical Nurses, two Registered Nurses, approximately 45 residents and family members.

The inspector(s)completed interviews, reviewed health care records, observed resident care, reviewed relevant policies, and other reports as needed.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

- **12 WN(s)**
- **7 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 failed to ensure that where bed rails were used the resident had been assessed to minimize risk to the resident.

Observation of resident # 006’s bed system revealed bed rails were in use. Record review revealed there was no documented assessment for the use of the bed rails. Record review of the "Bed Entrapment Assessment" revealed the entrapment inspection for the bed system indicating the use of one or more bed rails.

Observation of resident # 008’s bed system revealed bed rails in use. Record review revealed there was no documented assessment for the use of the bed rails. Record review of the "Bed Entrapment Assessment" revealed the entrapment inspection for the bed system indicating the use of one or more bed rails.

Observation of resident # 021’s bed system revealed bed rail in use. Record review revealed there was no documented assessment for the use of the bed rails. Record review of the "Bed Entrapment Assessment" revealed the entrapment inspection for the bed system indicating the use of one or more bed rails.

Observation of resident # 044’s bed system revealed bed rails in use. Record review revealed there was no documented use of bed rails. Resident changed bed systems to a new bed system with no "Siderail Utilization Assessment" completed in the new bed. Record review of the "Bed Entrapment Assessment" revealed the entrapment inspection for the bed system indicated the use of one or more bed rails.

Staff interview with the Director of Nursing (DON) # 102 February 24, 2016 at 1100 hours confirmed that the “Siderail Utilization Assessment” was to be completed on admission, quarterly or when the resident changed bed systems and confirmed that the “Bed Entrapment Assessment” was to be completed when there was a change to the bed system itself. The DON confirmed the “Siderail Utilization Assessments” completed for resident # 006, 008, 021 and 044 did not document the use of bed rails and confirmed bed rails are in use for all four residents. The DON # 102 confirmed where bed rails were used the residents had not been assessed to minimize risk. [s. 15. (1) (a)]

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. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be properly groomed and cared for in a manner consistent with his or her needs was fully respected and promoted.

Observation on February 18 and 24, 2016 revealed resident # 006 had not been groomed.

Staff interview confirmed grooming normally occurs during a bath routine. Record review of the POC task “Bath” revealed resident # 006 had eight baths without being properly groomed. [s. 3. (1) 4.]

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 the resident's right to be properly groomed and cared for in a manner consistent with his or her needs was fully respected and promoted, to be implemented voluntarily.

WN #3: 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. (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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

An observation of resident # 006's room revealed the use of bed rails.

Record review revealed there were two different interventions related to the use of bed rails.

Staff interview with the Director of Nursing # 102 at 1100 hours confirmed the current plan of care for resident # 006 did not set out clear directions to staff and others who provide direct care to the resident related to the use of bed rails. [s. 6. (1) (c)]

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 the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee has failed where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, was in compliance with and was implemented in accordance with applicable requirements under the Act; and is complied with.

A review of a Critical Incident Report revealed that resident # 048 was left unattended during during care.

The Employee Orientation and Training Policy:

Each employee, including agency staff, will receive information and/or training about the following at hire and annually.

• Safe and correct use of equipment including therapeutic equipment, mechanical lifts, assistive aids, positioning aids, relevant to the Employee's Responsibility".

A review of the mandatory "annual training" was last completed in 2014.

The residents plan of care also showed that the resident was not to be left unattended during care

The Nursing Care Manager # 104 confirmed that the staff member should have had training in 2015, but had not. [s. 8. (1)]

2. The licensee failed to ensure that the policy Complaints and Concerns dated November 30, 2010, was complied with.

During a family interview, the family stated they had resident care concerns.

An interview with the Administrator #100 on February 29, 2016, revealed a Registered Practical Nurse had received a complaint of resident care concern.

The staff had documented the family complaint in point click care.

A review of the policy Complaints and Concerns revealed “all complaints and concerns, whether verbal, email, written or voice mail are to be documented on the Client Service Response Form and the Response and Resolution Form for performance quality improvement initiatives”.

The interview with the Administrator #100 confirmed the staff did not document the complaint on the Client Service Response Form and the Response and Resolution Form for performance quality improvement initiatives and it was the homes expectation that the policy should have been followed. [s. 8. (1) (b)]

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 the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, and compliance with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times.

On February 18, 2016, an observation of a residents bathroom showed that the call bell cord was wrapped around the grab rail and was not easy accessed and used by the resident.

Staff confirmed that the call bell was wrapped around the grab bar and was not easily used by the resident's in the room.

The Administrator # 100 Confirmed that the call bell should have been easily seen, accessed and used by residents, at all times. [s. 17. (1) (a)]

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 the resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Record review of Critical Incident reports on three dates over a four month period revealed inappropriate behaviours.

Record review of the plans of care for resident # 015 and # 019 on February 24, 2016 revealed neither resident had interventions to alert care staff of the risk of altercations and potentially harmful interactions between these two residents.

Staff interview on February 29, 2016 at 1430 hours confirmed staff have access to POC and to the plan of care through the kardex only and confirmed resident # 015 and # 019 did not have specific interventions in the plan of care to alert staff of the behaviours. The staff confirmed there are no monitoring interventions in resident # 019's plan of care to minimize the risk of altercations and potentially harmful interactions between these two residents. [s. 54. (b)]

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 steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were monitored during meals.

Observations by inspector #610 in the dining room revealed eight residents seated for the lunch time meal. These residents required assistance, cuing and monitoring at meals. All eight residents had beverages served.

An interview with staff confirmed that all eight residents were not monitored in the dining room for thirty minutes with their beverages and it was the homes expectation that all residents were to be monitored during meals. [s. 73. (1) 4.]

2. The licensee has failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

Observations in the dining room revealed four residents seated and one staff member present at the table. The staff member was assisting two of the four residents. Resident #025 had fallen asleep.

These observations continued at 1230, 1235, 1245 hours.

A review of the temperature log book revealed the spaghetti was served at 85 degrees Celsius.

The Nutritional Manager #109 took the temperature of resident's #025 meal on the table. The temperature of the meal was recorded at 46 degrees Celsius.

The Nutritional Manager #109 at 1245 hours revealed resident #025 had been served the meal before a staff member was available to assist the resident with eating.

The Nutritional Manager # 109 confirmed it was the homes expectation that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance. [s. 73. (2) (b)]

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 steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions and to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #8: 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 failed to ensure that all staff participate in the implementation of the infection control program.

An observation of the resident's room showed that the Resident # 050 had an isolation cart with Personal Protective Equipment (PPE) and signage on the door for droplet Precautions.

Staff were observed assisting resident # 050 to the bathroom without PPE usage. The staff revealed that the resident was not on isolation. A review of the Risk management report showed that the resident had been on isolation.

Two rooms were observed to have care carts with care supplies in the residents rooms. One Resident's room had precautions posted on the door with a care cart in the room.

The Policy Additional Precautions:

" 5.2 Droplet Precautions - used for residents known or suspected to have microorganisms transmitted by large particle droplets.

The Policy Routine Practices:

4.1 Routine Practices as they Pertain to the Resident Care

- the use of personal protective equipment

- management of the resident care environment

- handling of waste and linen".

The Registered Nurse # 122 confirmed that the care carts should not be in the resident's room and removed the carts.

The Director of Nursing (DON) confirmed that they should not be storing the carts in residents room and confirmed they should be using PPE when providing direct care to affected residents. [s. 229. (4)]

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 all staff participate in the implementation of the infection control program, to be implemented voluntarily.

WN #9: 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 the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A critical incident was submitted related to alleged abuse, from resident to resident and was documented in the residents Health Care Record (HCR).

The Policy Prevention, Elimination, and Reporting Abuse Procedure:
• The Registered staff member must immediately contact the Administrator, Director of Nursing or delegate.

A review of the internal investigation notes showed that the staff documented the incident and failed to report the incident to the manager on call. [s. 20. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistive Safety Device (PASD) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Observation of the resident revealed the resident was using an assistive device.

Staff interview on March 1, 2016 at 1115 hours with the Nurse Manager # 104 and staff # 111 confirmed the resident was using a PASD.

Record review of resident # 008's paper chart revealed there was no consent related to the use of the PASD [s. 33. (4) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all menu substitutions were communicated to residents and staff.

A dining observation on February 16, 2016, revealed the menu posted included butterscotch pudding for the lunch time dessert. Further observations on February 16, 2016, revealed residents on the 3rd floor dining room were offered a dessert square or a fruit salad for the lunch time dessert.

An interview on February 16, 2016, with Personal Support Worker # 110 confirmed the menu item had been changed but was not aware of the reason why.

An interview with the Nutritional Manager #109 on February 19, 2016, confirmed the menu substitution on February 16, 2016, was not communicated to residents and staff. [s. 72. (2) (f)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A critical incident was reported to the Director.

Resident # 048 was left unattended during care. A review of the risk management investigation, showed that the resident's Substitute Decision Maker (SDM) had not been notified of the incident.
A review of the Prevention, Elimination of Reporting of Abuse Procedure:

• The Administrator /DON/delegate will ensure that the residents representative/POA/SDM is informed of the incident immediately and of the status of the investigation. Ideally, a family conference will be scheduled as soon as possible following the incident….."

The DON #102 confirmed that it is the home's policy that the resident SDM should have been notified within 12 hours upon the licensee becoming aware of the incident.

Issued on this 1st day of April, 2016

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

Original report signed by the inspector.

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	NATALIE MORONEY (610), MELANIE NORTHEY (563), REBECCA DEWITTE (521)
Inspection No. / No de l’inspection :	2016_254610_0006
Log No. / Registre no:	002282-16
Type of Inspection / Genre d’inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 16, 2016
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 :	Jan Shkilnyk

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

Order # / Ordre no : 001

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

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 shall ensure:

1. Resident # 's 006, 008, 021, and 044 will be assessed for the use of bed rails and this assessment will be documented in the resident's health record.

2. The residents' plans of care are to be reviewed and updated to be consistent with the completed assessments.

3. An audit will be completed on all residents using bed rails to ensure an assessment has been completed.

4. Staff will be educated to ensure they are aware that any changes in bed rails use must be assessed and documented.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used the resident had been assessed to minimize risk to the resident.

Observation of resident # 006's bed system revealed bed rails were in use. Record review revealed there was no documented assessment for the use of the bed rails. Record review of the "Bed Entrapment Assessment" revealed the

entrapment inspection for the bed system indicating the use of one or more bed rails.

Observation of resident # 008's bed system revealed bed rails in use. Record review revealed there was no documented assessment for the use of the bed rails. Record review of the "Bed Entrapment Assessment" revealed the entrapment inspection for the bed system indicating the use of one or more bed rails.

Observation of resident # 021's bed system revealed bed rail in use. Record review revealed there was no documented assessment for the use of the bed rails. Record review of the "Bed Entrapment Assessment" revealed the entrapment inspection for the bed system indicating the use of one or more bed rails.

Observation of resident # 044's bed system revealed bed rails in use. Record review revealed there was no documented use of bed rails. Resident changed bed systems to a new bed system with no "Siderail Utilization Assessment" completed in the new bed. Record review of the "Bed Entrapment Assessment" revealed the entrapment inspection for the bed system indicated the use of one or more bed rails.

Staff interview with the Director of Nursing (DON) # 102 February 24, 2016 at 1100 hours confirmed that the " Siderail Utilization Assessment" was to be completed on admission, quarterly or when the resident changed bed systems and confirmed that the "Bed Entrapment Assessment" was to be completed when there was a change to the bed system itself. The DON confirmed the "Siderail Utilization Assessments" completed for resident # 006, 008, 021 and 044 did not document the use of bed rails and confirmed bed rails are in use for all four residents. The DON # 102 confirmed where bed rails were used the residents had not been assessed to minimize risk. [s. 15. (1) (a)] (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 13, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de sions de longue durée
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 Inspection de sions de longue durée 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 16th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Natalie Moroney

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