



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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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Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 3, Sep 14, 2017	2017_418615_0018	008968-17, 008990-17	Complaint

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

HELENE DESABRAIS (615), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 26, 27, 28, 29 and 30, 2017.

**The following Complaint inspections were completed during this inspection:
Complaint Log #008968-17 / IL-50666-LO related to minimizing restraints, plan of care and falls prevention and Critical Incident Log #008990-17 / 1030-000012-17 related to prevention of abuse and neglect for the same resident.**

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a Nurse Manager (MN), one Registered Nurse (RN) and two Registered Practical Nurses (RPN).

The Inspectors also observed resident care provision, resident/staff interactions, reviewed residents' clinical records, the home investigation reports, education/training records, policies and relevant documentations.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

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

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :



1. The licensee has failed to ensure that the care provided to the resident was provided as specified in the plan of care.

On a specific day, a family member of a resident submitted a Ministry of Health and Long Term Care Complaint, and stated that they were concerned that care was not being provided to the resident as per the plan of care. The complainant indicated that they had attempted to resolve their issues within the home but that the concerns continued.

A review of the resident's care plan stated that they were to have specific interventions in place when the resident was using a device. There was a paper sign posted on the wall in the resident's room, and the care plan also indicated the specific interventions.

During an interview, an RPN stated they had spoken directly to the Power of Attorney (POA) of the resident, and that the current care plan and interventions had been developed based on a discussion, and had been consented to by the POA. The DOC was also present for this interview and stated that they had also reviewed the content of the complaint and had followed up with the POA, addressing each area of the complaint, followed by a written response letter, and stated that the interventions as outlined in the care plan were consented to by the resident's POA.

During an interview, a PSW was able to state the specific interventions for the resident.

On a specific date, the resident was observed by the Inspector, using a device without the specific interventions in place. Two PSWs also observed the resident at that time, and stated that the interventions were not in place.

During an interview, the DOC stated that it was the home's expectation that care would be provided to residents as specified in the plan of care.

The severity was determined to be a level 2 as there was minimal harm or potential for actual Harm. The scope of this issue was determined to be isolated during the course of this inspection. There was a no compliance history of this legislation being issued in the home. [s. 6. (7)]



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Issued on this 14th day of September, 2017

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

Original report signed by the inspector.