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
Jan 24, 2018	2017_674610_0018	028035-17	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

NATALIE MORONEY (610)

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): December 22, 2017.

The following concurrent inspections were conducted during the the Critical Incident System Inspection related to Falls Management and Prevention:
Critical Incident (CI) #1030-000025-17/Log #028035-17
Critical Incident (CI) #1030-000023-17/Log #025469-17

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Director of Clinical Services, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

Inspector also observed resident care provision, resident and staff interactions, reviewed relevant resident clinical records, relevant policies and procedures and other records pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 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 set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to falls prevention.

Further review of the documentation showed that staff had reported that they did not followed the plan of care for safety interventions for the resident and the resident fell.

Further review of documentation showed the resident was found on the floor and was assessed by the registered staff. At the time of the assessment the resident had complained of pain and was provided medication. The resident was later sent to the hospital where it was determined that the resident had sustained an injury related to the fall.

During an interview, the nursing staff stated that another staff member had forgotten to apply a device to decrease the risk of falls for the resident.

During an interview, the staff said that they did not follow the resident's plan of care and should have had the device applied to the resident to mitigate the fall risk

During an interview, the Administrator explained that the staff did not provide the care for the resident as specified in the plan of care by applying the device to the resident for falls prevention.

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

The severity was determined to be a level three as there was actual harm. The scope of this issue was isolated during the course of this inspection. The home does have a history of noncompliance in a similar area of this subsection of the legislation. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 25th day of January, 2018

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

Original report signed by the inspector.