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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 21, 2014	2014_183135_0004	L-000023-14	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF MIDDLESEX
c/o Strathmere Lodge, 599 Albert Street, P.O. Box 5000, STRATHROY, ON, N7G-3J3

Long-Term Care Home/Foyer de soins de longue durée

STRATHMERE LODGE
599 Albert Street, Box 5000, STRATHROY, ON, N7G-3J3

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

BONNIE MACDONALD (135)

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): January 10, 2014.

During the course of the inspection, the inspector(s) spoke with Director of Resident Care, Registered Nurse, Dietitian, Personal Support Worker, Health Care Aide, Dietary Aide and Resident.

During the course of the inspection, the inspector(s) reviewed resident's clinical records, critical incident report and nutrition policy and procedures. Observations took place in resident home area and during lunch meal service.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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, where bed rails are used that the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident when the following occurred:

A critical incident report was submitted by the home indicating that resident was transferred to hospital.

Record review revealed the resident had not received a full assessment to determine if their bed system (bed frame, mattress and bed rails) was appropriate for their needs.

During an interview the Clinical Support Nurse revealed residents have not had their bed systems evaluated in accordance with evidence-based practices.

During an interview the Director of Resident Care confirmed his expectation that when bed rails are used the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

2. January 10, 2014, the Director of Resident Care provided documentation that the home's beds were all assessed by a bed manufacturer on January 21, 2012, to determine compliance with Health Canada's "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards 2008".
The entrapment zones, if not managed, become areas where bodily parts can become

lodged and trapped. The audit, identified 88 (55.3 %) of the home's beds failed the bed entrapment zones between the rail and mattress. The home's six air mattresses were not tested as they automatically fail the zones of entrapment based on their design.

Since the audit, the management of the home have not instituted any measures to minimize or mitigate potential risk to the residents and have not conducted any clinical assessments of the residents that currently sleep on failed beds to determine if the bed system they have been provided is appropriate for their individual needs.

Existing assessment tools available to staff at the home are related to transfers and overall mobility and not specifically geared to bed safety. Bed safety assessments would require review of residents for sleep habits and patterns, the sleep environment, mobility in bed, cognition, communication, continence, risk of falls, medication and underlying medical conditions.

The management of the home as of January 10, 2014, have replaced 10 of the 88 beds and have plans to replace the remaining failed beds at the rate of 10 beds per year or as budget allows. However the home was not able to provide any current plans outlining specifically what will be instituted to mitigate risk to residents who continue to sleep in beds that have identified safety risks.

During an interview, the Director of Resident Care confirmed his expectation that when bed rails are used, the resident be assessed and his or her bed system evaluated and steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

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 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is
complied with when the following occurred:

The home's Food and Fluid Recording Intake policy NMF009 September 26, 2013, states:
• Any resident who is noted to have consumed less than 75% of their recommended fluid intake over a 48 hour period will be reported to the Registered Staff in charge of the home area.
• The Registered Staff member will assess and determine a corrective action and/refer to the Dietitian for consultation.

Record review revealed [redacted], the resident's fluid intake was below 75% of their recommended fluid intake of 1500 mls./day over a 48 hour period on the following occasions:

[redacted], resident's average fluid intake over 72 hrs. was 35.7% of the recommended intake.
[redacted], resident's average fluid intake over 96 hrs. was 38.9% of the recommended intake.
[redacted] resident's average fluid intake over 72 hrs. was 36.4% of the recommended intake.

During an interview the Registered Dietitian confirmed, the resident is at high nutritional risk for poor food and fluid intake and she had not received a referral for resident's poor fluid intake during December, 2013.

During an interview the Director of Resident Care confirmed his expectation that the licensee of the home ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with related to residents poor fluid intakes. [s. 8. (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 ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with related to residents poor fluid intakes, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The Licensee failed to ensure that the home's Registered Dietitian who is a member of the staff of the home completed a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition as evidenced by the following:

During lunch service observations, January 10, 2014, resident received a [redacted] diet and not the [redacted] diet as per the resident's nutritional plan of care.
During an interview the Dietary Aide confirmed the resident "has been on Puree diet for at least 2 weeks now" [redacted]

The home's Dietitian confirmed the resident who is at high nutritional risk related to ongoing weight loss was not referred for assessment when there was a significant change in resident's eating ability.

During an interview the Director of Resident Care confirmed his expectations that the home's Dietitian complete a nutritional assessment for the resident on admission and whenever there was a significant change in the resident's health condition. [s. 26. (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 ensuring that a nutritional assessment is completed for the resident on admission and whenever there is a significant change in the resident's health condition, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented when the following occurred:

High nutritional risk resident's care plan states: Monitor and record intake in flow sheets
Record review revealed the resident's fluid intakes for snack service were not documented for the month of December 2013, as follows:

Am. Snack fluid documentation missing, 71% of the time
PM. Snack fluid documentation missing, 58% of the time
HS. Snack fluid documentation missing, 77.4% of the time

During an interview the Dietitian confirmed her expectation that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented [s. 30. (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 ensuring that residents' responses to interventions related to fluid intakes are documented, to be implemented voluntarily.

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

Issued on this 21st day of January, 2014

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

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BONNIE MACDONALD (135)
Inspection No. / No de l'inspection :	2014_183135_0004
Log No. / Registre no:	L-000023-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 21, 2014
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF MIDDLESEX c/o Strathmere Lodge, 599 Albert Street, P.O. Box 5000, STRATHROY, ON, N7G-3J3
LTC Home / Foyer de SLD :	STRATHMERE LODGE 599 Albert Street, Box 5000, STRATHROY, ON, N7G-3J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TONY ORVIDAS

To THE CORPORATION OF THE COUNTY OF MIDDLESEX, 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) (b)

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 must prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s.15. 1 (a) (b) that includes:

1. An immediate review of the bed system provided to determine if it is appropriate for the needs of residents with an air mattress:

2. What interventions will be implemented to mitigate risks to the remaining 78 residents that use one or more bed rails for beds that failed any zone of entrapment. This includes all beds, whether the mattress is foam based or not.

3. How residents will be assessed to determine if their bed system (rail, mattress and frame) is appropriate for their needs.

4. The plan must include confirmation with dates of when the assessment for the identified residents will be completed, care plans updated and what interventions will be put into place.

5. Identify what long term measures will be implemented to ensure beds continue to pass all zones of entrapment and the time lines.

6. Summarize how and when staff have been or will be trained and orientated with respect to bed safety.

7. Include a copy of the home's finalized bed safety policy and procedure.

Please submit the plan in writing, to Bonnie.MacDonald Long-Term Care Homes Inspector, Ministry of Health and Long Term Care Performance Improvement and Compliance Branch 130 Dufferin Avenue 4th Floor London Ontario N6A 5R2, by email bonnie.macdonald @ontario.ca by February 24, 2014.

Grounds / Motifs :

1. The licensee failed to ensure, where bed rails are used that the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident when the following occurred:

A critical incident report was submitted by the home indicating that resident was transferred to hospital.

Resident's mattress was designed without side re-enforced walls or side bolsters to minimize mattress edge compressibility and both quarter bed rails were in the raised position .

Record review revealed the resident had not received a full assessment to determine if their bed system (bed frame, mattress and bed rails) was appropriate for their needs.

During an interview the Clinical Support Nurse revealed residents have not had their bed systems evaluated in accordance with evidence-based practices.

During an interview the Director of Resident Care confirmed his expectation that when bed rails are used the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.
(135)

2. January 10, 2014, the Director of Resident Care provided documentation that the home's beds were all assessed by a bed manufacturer on January 21, 2012, to determine compliance with Health Canada's "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards 2008".
The entrapment zones, if not managed, become areas where bodily parts can become lodged and trapped.
The audit, identified 88 (55.3 %) of the home's beds failed the bed entrapment zones between the rail and mattress. The home's six air mattresses were not tested as they automatically fail the zones of entrapment based on their design.

Since the audit, the management of the home have not instituted any measures to minimize or mitigate potential risk to the residents and have not conducted any clinical assessments of the residents that currently sleep on failed beds to determine if the bed system they have been provided is appropriate for their individual needs.

Existing assessment tools available to staff at the home are related to transfers and overall mobility and not specifically geared to bed safety. Bed safety

assessments would require review of residents for sleep habits and patterns, the sleep environment, mobility in bed, cognition, communication, continence, risk of falls, medication and underlying medical conditions.

The management of the home as of January 10, 2014, have replaced 10 of the 88 beds and have plans to replace the remaining failed beds at the rate of 10 beds per year or as budget allows. However the home was not able to provide any current plans outlining specifically what will be instituted to mitigate risk to residents who continue to sleep in beds that have identified safety risks.

During an interview, the Director of Resident Care confirmed his expectation that when bed rails are used, the resident be assessed and his or her bed system evaluated and steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.
(135)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 21st day of January, 2014

Signature of Inspector / Signature de l'inspecteur : Bonnie MacDonald

Name of Inspector / Nom de l'inspecteur : BONNIE MACDONALD

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