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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Dec 16, 2015	2015_326569_0023	029507-15	Resident Quality Inspection

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

DONNA TIERNEY (569), MARIAN MACDONALD (137), RUTH HILDEBRAND (128)

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): November 2, 3, 4, 5, 6, 7, 9, 10, 12, 13, and 16, 2015.

The following Critical Incident inspections were conducted concurrently: Log #025204-15/CI M627-000027-15 and Log #015891-15

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Resident Care (ADRC), the Environmental Service Manager (ESM), the Recreation Manager, the Food Service Manager, the Clinical Support Nurse, the Nursing Co-ordinator, the Resident Assessment Instrument Minimum Data Set Co-ordinator (RAI-MDS), the Staff Educator, an attending Physician, the Physiotherapist (PT), a Physiotherapy Assistant (PTA), the Administrative Support Nurse, the Family Council Chair, the Resident Council Chair, members of the Restraints and Falls Prevention Committee, a Recreation Adjuvant, a Volunteer, a Receptionist, a Maintenance worker, a private caregiver, a Dietary Aide, 2 Food Service Workers, 8 Registered Nurses (RN), 7 Registered Practical Nurses (RPN), 17 Personal Support Workers (PSW), Family members, and over 40 Residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **11 WN(s)**
- **9 VPC(s)**
- **2 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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required it, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A clinical record review for an identified resident revealed there was no documented evidence that a continence assessment was completed, as per the legislative requirements.

A three day voiding diary was partially completed which indicated if the resident requests to be toileted, if staff toilet the resident, if they have voided, if they are incontinent, and which product was used. The diary did not identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

During interviews with a Registered Practical Nurse (RPN) and the Acting Director of Resident Care (ADRC), it was revealed that the home considers the three day voiding diary as a continence assessment tool.

Both acknowledged the home's three day voiding diary tool did not meet the legislative requirements and the expectation was the home complete continence assessments that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence. [s. 51. (2) (a)]

2. A clinical record review revealed that the annual Resident Assessment Instrument (RAI) assessment for two identified residents indicated that they were frequently incontinent of bladder. There was no documented evidence in the clinical record to demonstrate that an assessment was completed that identified causal factors, type of incontinence, and potential to restore function with specific interventions.

Two RPN's acknowledged that the only continence care assessments completed for the identified residents were three day voiding records. Additionally registered nursing staff

confirmed neither of those residents were on the restorative toileting program.

The ADRC confirmed the home did not conduct continence assessments that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions for all residents who were incontinent. She indicated that continence care assessments were only done for residents who qualified to be on the restorative toileting program. [s. 51. (2) (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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written description of the continence care program that included its goals and objectives, relevant policies, procedures and protocols, methods to reduce risk, methods to monitor outcomes, and protocols for referral of residents to specialized resources where required.

A review of the continence care program, by Inspectors #128 and #137 revealed that the home did not have policies and procedures in place to meet compliance with section 51 of the regulation.
There was no documented evidence to support that there were goals and objectives, methods to reduce risk nor methods to monitor outcomes to residents.

The Acting Director of Resident Care (ADRC) acknowledged that there were no goals and objectives for the continence care management program. She confirmed that the program was not fully developed and implemented. [s. 30. (1) 1.]

2. The licensee failed to ensure that there was a written description of the pain management program that included its goals and objectives, relevant policies, procedures and protocols, methods to monitor pain management, and protocols for referral of residents to specialized resources where required.

A review of the pain management program revealed that the home does not have goals, objectives, relevant policies, procedures and protocols, methods to monitor pain management and protocols for referral of residents to specialized resources where required, to meet compliance with section 52 of the regulation.

The ADRC confirmed the home does not have a pain management program in place other than the Assessment of the Communicative Resident Tool, Policy # NMP002, reviewed July 12, 2012, and the Assessment of the Non-Communicative Resident Tool, Policy # NMP0003, reviewed August 7, 2014.

The ADRC acknowledged that there were no goals and objectives for the pain management program and the program was not fully developed or implemented. [s. 30. (1) 1.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 there is a written description of the continence care program that includes its goals and objectives, relevant policies, procedures, and protocols, methods to reduce risk, methods to monitor outcomes, and protocols for referral of residents to specialized resources where required, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

a) During the initial tour on September 2, 2015 at 1045 hours, the electrical room door near the Spa on Arbour Glen unit was observed unlocked and unattended. On the floor was a tool bag containing more than 15 screwdrivers, a pair of wire cutters, and a hand saw. The tools were accessible to residents, posing a potential safety risk. The contractor returned to the room approximately three minutes later.

A Personal Support Worker (PSW)confirmed the electrical room door was unlocked and the tools were unattended.

During an interview, the Environmental Services Manager (ESM) shared that a conversation occurred with the contractors about having left the electrical room door unlocked. The ESM had previously reminded the contractors to make sure doors were locked and tools and wires were not accessible to residents.

The ADRC confirmed the door was unlocked and unattended, and the tools were accessible to residents, posing a potential safety risk, as well as the expectation that the home was a safe and secure environment for its residents.

b) On November 9, 2015 at 1055 hours, a utility cart in the Arbour Glen hallway, was observed unattended. There was a large tool bag on the bottom shelf containing several screwdrivers and various other tools.

The contractor acknowledged that the cart and tools were left unattended. The ESM was made aware and confirmed the expectation that the home was to be a safe and secure environment for its residents. [s. 5.]

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 home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: 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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A clinical record review for an identified resident revealed the resident was to have dressing changes completed daily.

A review of the Treatment Administration Records (TAR) for the resident revealed the prescribed treatment was not administered on 4 days in a specified month, as ordered by a Nurse specialist and attending Physician.

During an interview with the ADRC it was confirmed that the prescribed treatment had not been administered as ordered and the expectation was the treatment be administered daily, as ordered by a Nurse specialist and attending Physician. [s. 6. (7)]

2. A clinical record for and identified resident revealed that an order was written on a specified date in September 2015. A review of the Medication Administration Record (MAR) revealed that the resident was not receiving what was ordered.

An RPN confirmed that the resident had not been receiving what was ordered on the specified date in September 2015, and that the order had not been processed.

The ADRC confirmed that the home's expectation was that the order should have been processed and the care set out in the plan of care should have been provided to the resident as specified in the plan. [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 was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: 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 policy, protocol, or procedure, instituted or otherwise put in place was complied with.

On November 3, 2015, observation revealed a Personal Support Worker (PSW) serving beverages from the snack cart in a resident home area. The PSW was observed to touch the potentially dirty door handle of the closed door to an identified resident room while wearing gloves. The PSW entered the room to ask the resident his/her preference of beverage and returned to the snack cart to prepare the beverage. The beverage was served to the resident with no evidence of hand hygiene being performed.

The PSW acknowledged that hand hygiene should have been used after touching the potentially dirty door handle of the resident room and confirmed that he/she had left the dirty gloves on and did not change them. The PSW then used hand sanitizer with the gloves still on.

A review of the home’s policy entitled Hand Washing, Policy #ICH 0001, dated November 8, 1999 and last reviewed July 8, 2014, indicated the following procedure:
HAND WASHING WILL BE DONE:
Before initial patient/patient environment contact
Before Aseptic procedure
After patient/patient environment contact
After body fluid exposure/risk.
WHEN IN DOUBT WASH YOUR HANDS.

The ADRC confirmed that the home’s expectation was the PSW should have performed hand hygiene before entering the resident room to query what the resident wanted for snack, after leaving the room before preparing the snack, and then after delivering the snack and leaving the room.

The ADRC indicated that the expectation was that gloves not be used while serving the snack cart and that gloves should not have had hand sanitizer applied to them. She also indicated that they teach the 4 points of hand hygiene during staff's annual education and acknowledged that the PSW had not complied with the home’s hand hygiene policy. [s. 8. (1)]

2. The licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with, specifically related to skin and wound care.

A review of "Procedure for Wound and Ulcer Assessment", Policy 3 SW010, reviewed May 5, 2015, revealed under Procedure #6: "Registered Staff will assess the wound weekly and complete a Wound Care Assessment Form. The assessment will consist of the following:
a. BWAT - Bates-Jensen Wound Assessment Tool
b. Percentage of wound healing calculation - % reduction in size over time
c. Wound related pain
d. Stage of wound/pressure ulcer
e. Braden Scale
f. PUSH - Pressure Ulcer Scale for Healing Tool 3.0 and Pressure Ulcer Healing Chart

A clinical record review for an identified resident revealed there was no documented evidence of a Wound Care Assessment Form as identified in the home’s policy.

The ADRC was unable to locate the Wound Care Assessment Forms and contacted the

Clinical Support Nurse (CSN) by telephone. The CSN shared that the Wound Care Assessment Forms were not being completed. The CSN shared he/she utilizes a self-developed form which indicates the resident's name, stage, area, treatment, assessment and measurement.

The ADRC confirmed the "Procedure for Wound and Ulcer Assessment" was not being followed and the expectation was the policy be complied with. [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 that any policy, protocol, or procedure, instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

Observations during the initial tour during Stage one of the Resident Quality Inspection (RQI) revealed dust/lint in 28/40 (70%) resident washroom air vents and in 3/5 (60%) Spa air vents.

During a tour on November 10, 2015 at 1515hours, the Environmental Services Manager (ESM) confirmed the presence of dust/lint in the air vents and the home's expectation that the vents were to be kept clean. [s. 15. (2) (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 home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opened to the outdoors and was accessible to residents cannot be opened more than 15 centimetres.

Observations on November 5, 2015 at 1400 hours on a specified resident home area revealed bedroom windows of 3 resident rooms opened approximately 33 cm.

At 1430 hours the Environmental Services Manager (ESM) was made aware. The ESM shared maintenance workers were working on the windows to ensure they could not be opened more than 15 centimetres.

Observations on November 6, 2015 at 0900 hours revealed the bedroom windows of those same resident rooms still opened approximately 33 cm. At 0916 hours the ESM was made aware and directed the maintenance worker to restrict the window openings.

The ESM confirmed the identified windows opened beyond 15 centimetres and the home's expectation was that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres. [s. 16.]

2. On November 3, 2015, observation of the window in a resident room of a specified resident home area revealed that it opened 26 centimetres.

On November 4, 2015, the windows of three resident rooms on another resident home area were observed to open greater than the allowable 15 centimeters.
The ESM confirmed the observations that the windows were not restricted to 15 centimetres of these identified rooms.

Observations of the identified windows on November 5, 2015 revealed that the risk had not been mitigated. The ESM indicated that the maintenance workers were working on restricting the windows.

The ESM acknowledged that the expectation was that all windows in the home should be restricted to opening no greater than 15 centimetres. [s. 16.]

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 every window in the home that opened to the outdoors and was accessible to residents cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff.

A clinical record review for a identified resident revealed the resident had a wound which required dressing changes to be completed daily.

A review of the Wound Care sheets over a three month period in 2015 for the identified resident revealed there was no documented evidence that the resident had been reassessed at least weekly by a member of the registered nursing staff, except for one day in a specified month in 2015.

During interviews with the Acting Director of Resident Care and a Registered Practical Nurse, it was confirmed that the weekly wound assessments were not completed for the identified resident and the expectation was that residents with wounds were reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A review of the Minimum Data Set (MDS) Assessments for an identified resident revealed the resident was observed to have had no exhibited or expressed pain in one month in 2015, and moderate pain less than daily on a subsequent assessment three months later.

Record review revealed there was no documented evidence that a pain assessment was initiated or completed when the assessment indicated moderate pain less than daily.

A clinical record review of the Facial Grimace Assessment Flow Chart for the Cognitively impaired for the identified resident revealed three assessments completed for one shift only for a specified month in 2015.

There was no documented evidence that any further pain assessments were completed for the identified resident to date.

Interview with the Acting Director of Resident Care (ARDC) confirmed that no pain assessment was initiated or completed when the MDS Assessment in August, 2015 indicated moderate pain less than daily, that the resident's pain had not been monitored and assessed as per the suggestions of medical consultants, and that the Facial Grimace Assessment Flow Chart for the Cognitively Impaired, for the identified resident was not fully completed in a specified month in 2015.

The ADRC acknowledged that the home's expectation was that when the resident's pain was not relieved by initial interventions, the resident would be assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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 to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #10: 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

A resident was observed being assisted with eating in the dining room of a specified home area at the lunch meal on November 2, 2015. The resident was positioned at approximately a 100 degree angle, and the Recreation-Adjuvant who was assisting the resident with eating, was noted to be feeding the resident with a fork at approximately 12 inches below the resident's eye level.

The Recreation-Adjuvant acknowledged that he/she should have been at eye level to safely feed the resident.

The Food Service Manager (FSM) acknowledged the potential risk and indicated that staff were expected to ensure safe feeding of residents by making certain that the residents were sitting upright at a 90 degree angle. She also indicated that staff should be placing the food in the mouth straight and not at a higher or lower height than the resident.

The FSM confirmed that proper techniques were to be used to assist residents with eating including safe positioning, and that staff should be at eye level while assisting residents with eating. [s. 73. (1) 10.]

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 proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by a physical device was included in the resident's plan of care only if there was an order by the physician or the registered nurse in the extended class.

An identified resident was observed to be restrained in a specified chair throughout the Resident Quality Inspection.

A clinical record review conducted on November 13, 2015, for the identified resident revealed that there was no current order for a restraint. An order was originally written by the Physician on a specified date in 2014.

The last three month medication review for September 2015 to November 2015, did not have the order for the restraint renewed.

During a staff interview on November 13, 2015, a Registered Nurse confirmed that the order for the restraint was missed on the last three month medication review.

The Acting Director of Resident Care confirmed that the home's expectation was that all residents who were restrained by a physical device should have an order written and/or renewed on the three month medication review. [s. 31. (2) 4.]

Issued on this 17th day of December, 2015

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

Original report signed by the inspector.

Ontario

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

Ministére 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

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Inspection No. / No de l'inspection :	2015_326569_0023
Log No. / Registre no:	029507-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 16, 2015
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. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must prepare, submit, and implement a plan for achieving compliance with O. Reg, 79/10, s. 51. (2) (a).

The plan must include but is not limited to the following:

1. A written confirmation that the home will develop a continence assessment that meets all of the requirements outlined in the legislation.
2. The process to implement continence assessments for residents who are identified as incontinent.
3. How compliance will be monitored on an ongoing basis to the use of this tool.
4. Education of Registered Staff on the policy and procedure for assessing residents who are identified as incontinent.

The plan must also identify who will be responsible for completing the identified tasks and time frames when each of the components will be achieved.

Please submit the written plan to Donna Tierney, Long-Term Care Homes Inspector - Physiotherapy, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, ON N6A 5R2, via email to donna.tierney@ontario.ca by January 11, 2016.

Grounds / Motifs :

1. The licensee failed to ensure that, each resident who is incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for the assessment of incontinence.

A clinical record review revealed that the annual Resident Assessment Instrument (RAI) assessment for two identified residents indicated that they were frequently incontinent of bladder. There was no documented evidence in the clinical record to demonstrate that an assessment was completed that identified causal factors, type of incontinence, and potential to restore function with specific interventions.

Two RPN's acknowledged that the only continence care assessments completed for the identified residents were three day voiding records. Additionally registered nursing staff confirmed neither of those residents were on the

restorative toileting program.

The ADRC confirmed the home did not conduct continence assessments that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions for all residents who were incontinent. She indicated that continence care assessments were only done for residents who qualified to be on the restorative toileting program.

(128)

2. The licensee failed to ensure that, each resident who is incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for the assessment of incontinence.

A clinical record review for an identified resident revealed there was no documented evidence that a continence assessment was completed, as per the legislative requirements.

A three day voiding diary was partially completed which indicated if the resident requests to be toileted, if staff toilet the resident, if they have voided, if they were incontinent, and which product was used.

The diary did not identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

During interviews with a Registered Practical Nurse and the Acting Director of Resident Care, it was revealed that the home considers the three day voiding diary as a continence assessment tool.

Both confirmed the three day voiding diary tool did not meet the legislative requirements and the expectation was the home complete continence assessments that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment using a clinically appropriate assessment instrument that was specifically designed for the assessment of incontinence.

The scope of this issue was wide spread. The home did not have a history of non-compliance with this sub-section of the regulation. The severity of the issue was determined to be a level two with potential for safety and harm to residents. (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan for achieving compliance with O.Reg. 79/10, s. 30 (1) 1 regarding the pain management program.

The plan must include but is not limited to the following:

1. The process to develop and implement a pain management program that includes its goals and objectives and relevant policies, procedures and protocols, and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. How compliance will be monitored on an ongoing basis to the pain management program's policies and procedures.
3. Education of direct care staff to the pain management program.

The plan must also identify who will be responsible for completing the identified tasks and time frames when each of the components will be achieved.

Please submit the written plan to Donna Tierney, Long-Term Care Homes Inspector - Physiotherapy, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th Floor, London, ON, N6A 5R2, via email to donna.tierney@ontario.ca by January 11, 2016.

Grounds / Motifs :

1. The licensee failed to ensure that there was a written description of the pain management program that included its goals and objectives, relevant policies, procedures and protocols, methods to reduce risk, methods to monitor outcomes, and protocols for referral of residents to specialized resources where required.

A review of the pain management program revealed that the home did not have policies and procedures in place to meet compliance with section 52 of the regulation. There was no documented evidence to support that there were goals and objectives, methods to reduce risk nor methods to monitor outcomes to residents.

The Acting Director of Resident Care confirmed the home did not have a pain management program in place other than the Assessment of the Communicative Resident Tool - Policy # NMP002 - reviewed July 12, 2012 and the Assessment of the Non-Communicative Resident Tool - Policy # NMP0003 - reviewed August 7, 2014.

The Acting Director of Resident Care also acknowledged that there were no goals and objectives for the pain management program and that the program was not fully implemented.

The scope of this issue was wide spread. The home did not have a history of non-compliance with this sub-section of the regulation. The severity of the issue was determined to be a level two with potential for safety and harm to residents. (137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 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
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 16th day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Donna Tierney

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