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
Feb 1, 2018	2018_674610_0001	029376-17	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

NATALIE MORONEY (610), INA REYNOLDS (524), RHONDA KUKOLY (213), TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): January 8, 10, 11, 12, 15, 16 and 17, 2018.

Follow up to compliance order #001, #002 and #003 from Resident Quality Inspection #2017_532590_0008 related to compliance with the home's Wound and Ulcer Assessment policy, Medication Management policy, Medication Management System for storage and destruction of controlled substances and medication administration was completed during this inspection.

The following Critical Incident System (CIS) report inspections were conducted concurrently during this inspection:
CIS #M627-000016-16/Log #023525-16 Prevention of Abuse, Neglect and Retaliation
CIS #M627-000001-17/Log #000765-17 Prevention of Abuse, Neglect and Retaliation
CIS #M627-000004-17/Log #008745-17 Prevention of Abuse, Neglect and Retaliation
CIS #M627-000009-17/Log #018001-17 Prevention of Abuse, Neglect and Retaliation
CIS #M627-000018-17/Log #024854-17 Prevention of Abuse, Neglect and Retaliation
CIS #M627-000021-17/Log #029738-17 Falls Prevention and Management
CIS #M627-000020-17/Log #028416-17 Falls Prevention and Management

The following Complaint inspection was conducted concurrently during this inspection:
IL-47384-LO/Log #030403-16 Prevention of Abuse, Neglect and Retaliation, Falls Prevention and Management, and Skin and Wound Care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Food Service Manager, Clinical Educator, Dietary Aide, Recreational and Physiotherapy Manager, Housekeeper, Business Manager, families, Residents' Council representative and residents.

Inspector also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident and staff interactions, medication administration, medication storage areas, reviewed relevant resident clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 129. (1)	CO #001	2017_532590_0008	115
O.Reg 79/10 s. 131. (2)	CO #002	2017_532590_0008	115
O.Reg 79/10 s. 8. (1)	CO #003	2017_532590_0008	115

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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care by the home indicated that on an identified date, a resident fell resulting in an injury.

A review of the resident's six Post Fall Assessments, documentation showed that the five out of six falls resulted in an injury.

A review of the plan of care for the resident showed that there was no fall interventions in place to direct care staff on how to manage the falls for the resident even though the resident had fallen six times and did have injuries sustained as a result of the falls.

During an interview DOC stated that resident should have had interventions in place to mitigate falls risk and provide clear directions to staff to manage the safety risk related to the falls for the resident and had not. [s. 6. (1) (c)]

2. A Critical Incident System (CIS) report was submitted on an identified date to the MOHLTC from the home. On an identified date the resident had a change of condition at the home and was transferred to the hospital.

Further review of the CIS report showed that the hospital acknowledged the resident had a fall at the home. The electronic documentation for the resident showed the resident had three falls that had resulted in injury.

A review of the resident's plan of care showed that there were no interventions in place for staff to manage the resident's falls.

During an interview, the DOC stated that the resident should have had interventions in place to mitigate falls risk and provide clear directions to staff to manage the safety risk related to the falls and did not. [s. 6. (1) (c)]

3. The licensee has failed to ensure the provision of care set out in the plan of care was documented.

Record review of the plan of care interventions for the resident on an identified date showed that staff were directed to monitor and record the resident's intake.

Review of the Point of Care (POC) documentation for the resident, showed an identified period that there were instances where no documentation had occurred.

Nursing staff on an identified date, acknowledged that it was their understanding that the resident's intake was documented by the Personal Support Workers (PSW) for all meals and snacks. Nursing staff also told the Inspector that they documented the resident's intake electronically in POC. The nursing staff said that there were also options available in the POC flowsheets to indicate if the resident refused, was sleeping or was not available.

The Director of Care reviewed and acknowledged the missing documentation and indicated that the nursing staff were to monitor and document the resident's intake in the flowsheet as specified.

The licensee has failed to ensure that plan of care set out clear directions to staff and others who provided direct care to the resident and the provision of care set out was in the plan of care was documented. [s. 6. (9) 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 to ensure the plan of care sets out clear directions to staff and others who provide direct care to the resident, and to ensure the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff.

MOHLTC received a complaint on a specific date for an identified resident with several care issues.

Neglect is defined in Ontario Regulation 79/10, as "failure to provide a resident with the treatment, care, services or assistance required for health, safety, or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

A review of the resident health care record (HCR) showed that the resident required treatments monitoring and assessments for several areas of altered skin integrity.

Documentation in Med e-care for the resident showed that the resident had several areas of altered skin integrity during a specified period of time that indicated the resident at times was not receiving treatments, or assessments, related to those altered skin integrity areas.

Medication Treatment Administration Record for specified dates showed that the following treatments:
1) Altered skin integrity treatment to a specific area, documentation showed that treatment was given twice during a specified time period.
2) Altered skin integrity treatment to a specific area, documentations showed that the treatment was given twelve times during a specified time period.
3) Altered skin integrity treatment to a specific area, documentation showed that the treatment was completed 55 percent of the time during a specific time period.
4) Altered skin integrity treatment to a specific area, documentation showed that the treatment was completed 50 percent of the time during a specific time period.
5) Altered skin integrity treatment to a specific area, documentation showed that during a specific time period the treatment was provided three out of five times.

The licensee's policy Skin and Wound Management stated in part that registered staff will assess the wound weekly and document on the wound assessment form.

On a specified date the nursing staff documented that the resident had a specified area of altered skin integrity. The home was not able to provide any weekly assessments of the area after the first assessment.

Nursing staff told the Inspector that registered staff on the floor would treat skin integrity issues less than a stage II and all other stage able skin integrity concerns would be assessed, changed and measured by the nursing staff responsible for wound care and that referrals would be made if required to the wound care nurse who was in the home once a month.

The DOC showed the Inspector the documentation on Med -ecare that was to be used for all stage able skin integrity issues. On a specified date an assessment was completed by nursing staff for the for the area of altered skin integrity issues. There were no other completed assessments for the resident other area's of skin integrity alterations.

The DOC stated that they were aware of the altered skin integrity assessments and treatments were not being completed for the resident as the DOC stated they were told by the staff they did not have time to complete the assessments and treatments for the resident.

The licensee has failed to protect residents from abuse by anyone and shall ensure that

residents are not neglected by the licensee or staff. [s. 19. (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 to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: 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.

The home reported a CIS report on a specified date, the resident reported to a Personal Support Worker (PSW) that a visitor had inappropriately touched the resident.

Sexual abuse is defined in Ontario Regulation 79/10 as "any non-consensual touching or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member".

The health records for the resident were reviewed. Documentation by the nursing staff on a specific date, stated that the resident reported the occurrence to the nursing staff.

Progress notes documented by another nursing staff, showed that the resident remained upset about the incident that occurred with the visitor.

In an interview with the nursing staff on specific date said that they were made aware of the incident on that had occurred and said they were also aware at that time, that the resident had reported the incident to a another staff member previously and this was reported also to the DOC.

In an interview with the DOC, the DOC said that the two staff members who became aware of the incident should have notified the DOC at that time.

The home's Abuse policy stated "staff will notify their immediate supervisor, who will immediately notify the Director of Care of any alleged, suspected or witnessed incidents of abuse or neglect".

The licensee has failed to comply with the home's abuse policy when the Director of Care was not notified of an incident of alleged sexual abuse involving the resident.

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 there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A CIS report was sent to the MOHLTC on a specific day which stated that the resident reported to the nursing staff that resident had been inappropriately touched by a visitor. Sexual abuse is defined in Ontario Regulation 79/10 as "any non-consensual touching or remarks of a sexual nature or sexual exploitation directed towards a resident by a person

other than a licensee or staff member".

The documentation by a nursing staff stated that the resident reported to a PSW that a visitor came into their room and was inappropriate.

Progress notes documented by Registered Nurse (RN) stated that the resident remained upset about the incident that occurred with the visitor and was terrified of them.

In an interview the nursing staff said that they were made aware of the incident immediately reported it to the Director of Care (DOC) and contacted the police on a specific date.

In an interview with the DOC said that they were notified of the incident of alleged abuse of the resident and did not immediately reported the incident to the Director.

The licensee has failed to ensure that an incident of alleged abuse of the resident, which was reported to the DOC was immediately reported to the Director. [s. 24. (1)]

2. The licensee has failed to ensure that any person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was sent to the MOHLTC, on a specific date that related to improper treatment of care, to the resident from nursing staff.

A review of the complaint report showed that it was reported to the home, by the resident's family and that the resident had unexplained bruising on their arm and neck and that the home had started an investigation. Further review of the complaint showed that the family of the resident had witnessed and reported to the home improper treatment during a lift and transfer where one nursing staff was assisting the resident alone during a transfer.

A review of the home's "Abuse Policy" stated in part that the home would investigated every report of alleged, suspected, or witnessed incidents of abuse toward residents immediately and would immediately notify the MOHLTC.

On a specific date, documentation showed that the resident's family had reported that the

resident had not received the level of assistance required for a transfer. The resident's family was also upset, as there was altered skin integrity areas that could have been due to the transfer. The family reported that the resident had cried, and said the resident was being hurt by the staff. An email was sent to Administrator and DOC by the staff related to the concerns.

The DOC stated they had received verbal complaints from the family of the resident and provided documentation related to staff that had completed a lift transfer alone with the resident. The internal investigation notes showed disciplinary action was given on s specific date to the staff member.

The DOC stated that during the home's investigation the resident had bruising but they could not verify that the bruising was related to the improper care.

The DOC told the inspector they did not notify the MOHLTC immediately of an allegation of improper or incompetent treatment of care of the resident that could have resulted in harm or a risk of harm, the DOC stated the home had not submitted a Critical Incident System (CIS) report regarding the allegations of abuse and should have.

3. The home reported CIS report on a specific date to the MOHLTC related to allegations of abuse to the resident from the nursing care.

Verbal abuse is defined in Ontario Regulation 79/10 as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than the resident."

A review of the CIS report stated that on a specific date it was reported to DOC, by the resident's family that on a specific date, the resident told the family they were fearful of nursing staff as during care the resident reported that staff was shaking their fists at the resident and was speaking rudely to the resident. The family did not report the incident to DOC until a later date.

A review of the home's policy, "Abuse" stated in part that the home would investigate every report of alleged, suspected, or witnessed incidents of abuse toward residents immediately and would immediately notify the MOHLTC.

In an interview with the DOC they stated the investigation was immediately started on a

specified date when the home became aware off the alleged abuse. However the DOC also stated they did not inform the MOHLTC immediately and that the MOHLTC was not notified until, six days after the alleged abuse was reported to the home.

The licensee has failed to ensure that any person who had reasonable grounds that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (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 to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm had occurred, immediately reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #5: 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. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that a plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's health condition including pain.

During stage one of the Resident Quality Inspection the resident was identified as having pain. Record review on a specified date showed that under the pain symptom section for the resident indicated the resident complained or showed evidence of moderate to identified areas of the body related to a the residents health conditions. Documentation notes indicated the pain problems would be addressed in the care plan with the goal to keep the resident comfortable with little pain.

Record review of the most recent plan of care for the resident with respect to pain and comfort showed there was no focus statement, goals or interventions with respect to the resident's pain needs based on the assessment.

Interview with the nursing staff acknowledged the absence of goals and interventions related to the resident pain needs in the plan of care and that it was the home's expectation that there should be.

During an interview with Director of Care it was stated that they would expect that the plan of care was to include interventions related to the resident's pain based on the assessment. [s. 26. (3) 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 a plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's health condition including pain, to be implemented voluntarily.

Issued on this 5th day of February, 2018

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

Original report signed by the inspector.