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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 4, 2019	2018_789435_0003	002914-18, 010421-18	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

AMBERLY KERR (435), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 19 and 20, 2018.

The following intakes were completed in this Critical Incident System Inspection:
Log #002914-18, CIS #M627-000001-18 related to Prevention of Abuse and Neglect;
Log #010421-18, CIS #M627-000004-18 related to Falls Prevention and Management and;
Log #022476-18, CIS #M627-000007-18 related to Falls Prevention and Management, completed on January 3, 2019.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Nursing Coordinator, the Resident Assessment Instrument Coordinator, the Clinical Support Nurse, the Administrative Support Nurse, the Resident Clinical Nurse, Registered Nurses, Personal Support Workers and residents.

The inspectors also made observations of residents and care provided. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

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)**

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	Légende 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 that there was a written plan of care for each resident that set out, (a) the planned care for the resident; (b) the goals the care was intended to achieve; and (c) clear directions to staff and others who provided direct care to the resident.

The home reported a Critical Incident (CI) to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident that caused injury to an identified resident.

During an observation of the identified resident's room, Inspectors observed specific interventions in place. The identified resident was also observed to have specific interventions in place.

During an interview with the Director of Resident Care (DRC) they stated that the residents care plans, that all staff were to access, were found in a binder at the nurse's station on all units, and that staff were trained to look in the binder for the most up-to-date care plan. The DRC said that this printed document included hand written notes made by staff as updates did not occur until the next quarterly review where it would be electronically inputted on Mede-care, and printed to replace the version in the binder.

Review of the identified resident's paper copy care plan, found in the "Care Plan Binder" at the care area nursing station, and the electronic care plan found on Mede-care, did not have any planned care related to the use of the interventions observed in the resident's room or used by the resident. The electronic care plan for the identified resident found on Mede-care did not match the typed and printed copy found in the "Care Plan Binder".

During interviews of two Personal Support Workers (PSWs), as well as the Clinical Support Nurse (CSN), they all stated that the identified resident's care plan did not include direction for the interventions observed in the resident's room or used by the resident.

When two PSWs were asked how they would know if the identified resident used the interventions observed by Inspectors, they stated they would see it in the resident's room. When asked if they would know to, or how to, apply these interventions if they were not in the resident's room, they stated they would not.

When asked what a hand written note on the resident's paper copy care plan found in the "Care Plan Binder" directed them to do, the CSN and a PSW stated two different directions. When asked if this direction would be up to reader's interpretation, the CSN, and two PSWs stated that this direction would be up to reader's interpretation. One PSW stated that the care plan that all staff access was not clear.

During an interview a PSW stated that they did not have time to read the care plan in the "Care Plan Binder". When asked what PSW staff referenced to know how to provide care to residents, they stated that they used a "Cheat Sheet". When the Inspector requested a copy of this document, two PSWs verified that the information on the sheet, with a current revised date, did not accurately reflect the identified resident's current care needs.

The licensee failed to ensure that there was a written plan of care for an identified resident that set out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. [s. 6. (1)]

2. The licensee has failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had

convenient and immediate access to it.

The home reported a CI to the MOHLTC related to an incident that caused injury to an identified resident.

During an interview, the DRC stated that PSW staff had access to the kardex when they logged in to Point of Care (POC), however it was not always referenced as it was updated quarterly.

During an interview the DRC stated that the residents care plans all staff were to access, were found in a binder at the nurse's station on all units, and that staff were trained to look in the binder for the most up-to-date care plan.

When the Inspector requested a copy of the identified resident's most current care plan from a Registered Staff member, they stated that they would need to access the care plan in Mede-care, and did not refer to the binder.

During an interview with a PSW when asked what a kardex was, they stated that it was a quick review of the care plan. When asked if the identified resident's kardex they used to reference was up to date to reflect the care plan binder, they stated that it was not.

During review of the identified resident's printed care plan in the "Care Plan Binder" at the nursing station, a staff member required the use of the binder for reference. Inspectors had to wait to review the care plan binder until the staff member was finished with it, and had no immediate access to the identified resident's current care plan for this time.

Inspectors were provided another printed copy version of the resident's care plan, that was found on the Resident Assessment Instrument (RAI) Coordinator's desk with hand written update notes. When asked about this copy of the care plan document, the RAI Coordinator stated that it had been removed from the "Care Plan Binder" to be updated in the system. When asked what was left as a replacement for staff to have immediate access for the identified resident's care needs while they updated the care plan, they stated there was nothing.

The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it. [s. 6. (8)]

3. The licensee had failed to ensure that the following were documented: 1. The provision of the care set out in the plan of care. 2. The outcomes of the care set out in the plan of care. 3. The effectiveness of the plan of care.

The home reported a CI to the MOHLTC related to an incident that caused injury to an identified resident.

During an interview with a PSW they stated that they did not write progress notes, and that registered staff wrote progress notes. When asked if PSWs had access to read progress notes, they stated that they did not have access to read the notes through their Mede-care log in.

Review of an identified resident's care “Flow Sheet” for a specific month, the Kardex found on Mede-care, and "Observation/Flow" Sheet Monitoring for the identified month, revealed that there was no documentation for the provision, outcome or effectiveness for the use of interventions observed to be applied to the resident's care.

During an interview with a PSW when asked where they documented the provision, outcomes and effectiveness for the use of interventions observed to be applied to the resident's care, they stated that there was nowhere on POC to document this.

The licensee failed to ensure that the following were documented:
1) The provision of the care set out in the plan of care.
2) The outcomes of the care set out in the plan of care.
3) The effectiveness of the plan of care. [s. 6. (9)]

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 is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident; to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care and have convenient and immediate access to it and; to ensure that the following are documented: 1. The provision of the care set out in the plan of care. 2. The outcomes of the care set out in the plan of care. 3. The effectiveness of the plan of care, to be implemented voluntarily.

WN #2: 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

The home reported to the Ministry of Health and Long-Term Care (MOHLTC) a Critical Incident (CI) related to an incident of staff to resident physical abuse.

On an identified date, a complainant submitted a complaint letter to the home which was stamped as received. The letter stated, in part, that the identified resident had been complaining to them on a number of occasions that a Personal Support Worker (PSW) who was attending to their care was very abrupt with them and that they always felt that the PSW would leave their room angry. It continued to state that the PSW, went to the resident's room and told the resident to sit down and forcefully proceeded to assist with care, having no regard for the resident's pain due to disease process. A hand written note at the bottom of the letter stated that the DRC spoke with the complainant and the events were confirmed. A review of the identified resident's progress note on Mede-care also confirmed the above mentioned, as well that the CI report was submitted to the MOHLTC and reporting to the MOHLTC After-hours pager on an identified date. It also stated that the DRC spoke with the complainant and informed them that the staff member involved would be addressed and the complainant was accepting of this action.

During an interview, the DRC verified that the letter was received on an identified date and that they were aware of the incident and it was reported late to the MOHLTC.

The licensee has failed to ensure that the DRC who had reasonable grounds to suspect that abuse of an identified resident by the PSW that resulted in harm or risk of harm, 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 the person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident. Specifically failed to ensure that the Director was informed of an incident that caused an injury to a resident which resulted in hospitalization and resulted in a significant change in the resident's health condition.

A) The home reported a Critical Incident (CI) to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident that caused injury to an identified resident.

Review of the CI report noted that the incident occurred on an identified date, at which time the resident required and received intervention.

During an interview with the Director of Resident Care (DRC) they verified that they first became aware of the incident on an identified date. The DRC stated that the resident required and received intervention, as there was a significant change in the resident's health condition as stated in the CI report. The report was first submitted to the MOHLTC five business days after the change in condition occurred. The DRC verified that the report was submitted to the Ministry of Health and Long-Term Care late.

B) The home reported a CI to the MOHLTC related to an incident that caused injury to an identified resident.

Review of the CI report noted that the incident occurred on an identified date at which time the resident required and received intervention.

During an interview the DRC verified that the identified resident required and received intervention on an identified date as there was a change in their condition. The DRC stated that they knew that the resident had required and received intervention, however was unable to submit the CI report to the MOHLTC until their return to the home, three business days after the change in condition occurred.

The licensee had failed to ensure that the Director was informed of the incidents that caused an injury to identified residents for which the residents were taken to hospital and that resulted in a significant change in the resident's health condition. [s. 107. (3) 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 to ensure that the Director is informed of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who was permitted to administer a drug to himself or herself kept the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attended the resident, and in accordance with any conditions that were imposed by the physician, the registered nurse in the extended class or other prescriber.

During the inspection, the Inspector was observing staff interactions in the dining room. A identified resident was overheard complaining to Personal Support Worker (PSW) that they woke up with pills and water all over themselves. A Registered Nurse (RN) approached the resident and stated, "I know, I'm sorry, I'll replace them." The resident explained there was spilled water and pills all over them.

During an interview, the identified resident stated they came back to their room, sat down and fell asleep. The resident stated they woke up and must have knocked the water and pills over left on their table as there were pills and water all over the place. The identified resident was asked what time this happened and they replied, "just before lunch. I'm giving them a hard time. No one told me the pills were there." The resident also stated that they were administered a number of pills in the morning and demonstrated that the pills were poured on their lap where the resident took them one at a time.

During an interview the RN stated that they had left the identified resident's medications beside the resident in the resident's room. The RN explained that a PSW brought them the pills found on the floor and they were replaced. The RN stated the resident took two identified medications and the resident was watched at that time. The RN verified that the home's policy related to leaving medications at the resident's bedside required a physician's order. The RN was also asked about the number of medications the identified resident was administered in the morning. The RN explained that the resident would come to the medication room and took the medications in the medication cup on their assistive device and went back to their room where they self administered the medications. The RN verified that the resident had an identified diagnosis and they would not know if the resident actually took their medications.

Review of the identified resident's care plan noted that the resident was cognitively intact according to the most recent Minimum Data Set (MDS) Assessment.

The Director of Resident Care (DRC) verified that a physician's order would be required for the identified resident to self administer or keep them on their person or in their room and that the identified resident did not have an order to self administer at that time.

The "Medications-Resident Self-Administration at Bedside" policy: NMM008 last reviewed August 5, 2014 stated, "All medications shall be listed on the resident's Electronic Medication Administration Record. If a resident wishes to administer his/her own medications at the bedside, both a physician's order and a locking repository are required." "Once a physician's order and the locked container are in place, and once the preceding conversation has occurred, the resident's medications may be self-administered. Moreover, a gentle reminder to the resident should also be provided when they are due, and confirmation of the consumption of such medications should be obtained by questioning the resident whenever possible." "The self-administration of narcotics is not allowed. If a resident wishes to self-administer narcotics, a meeting must be arranged between the resident, family/POA, DRC, and attending physician to discuss

the matter further."

A progress note was created in Mede-care and stated, in part, that the undersigned was notified by PSW staff that the identified resident had spilled their medications in their room, on the floor. The identified resident stated to the undersigned that they had never done this previously. The resident had always self managed/manipulated their medications without incident. The medications were replaced and given. Query surrounding the resident's ability to self-administer medications, ie. without direct supervision, at anytime during the day. The progress note continued to state, in part, that the identified resident had diagnoses that created a barrier and indicated a high cognitive functioning score. The note concluded stating, in part, that registered staff would now monitor resident taking medications safely, until resident was able to speak directly with their physician regarding this issue. The resident would be placed on the physician list to assess resident's safety regarding, and surrounding self-administration and only if physician deemed appropriate, order to be obtained for resident to have medications at bedside.

The licensee has failed to ensure that the identified resident was authorized by a physician to self administer a drug, keep the drug on their person or in their room. [s. 131. (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 no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, and in accordance with any conditions that were imposed by the physician, the registered nurse in the extended class or other prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee has failed to ensure that the records of the residents of the home were kept at the home.

During an interview the Director of Resident Care (DRC) stated that the resident care plans all staff accessed, were found in a binder at the nurse's station, on all of the units, and that staff were trained to look in the binder for the most up-to-date care plan. They stated that this printed document included hand written notes made by staff as updates occurred to the care plan, until the next quarterly review, where it would be electronically inputted on Mede-care and printed to replace the version in the binder. During an interview with the Clinical Support Nurse (CSN) they stated that there were only four staff and the Resident Assessment Instrument (RAI) Coordinator trained to update the care plans on the Mede-care system.

Inspectors reviewed an identified resident's paper copy care plan found in the "Care Plan Binder" on a care area nursing station. There were three different hand written notes, dated on three different days, signed by staff indicating three different transfer methods for the resident.

Inspectors reviewed the identified resident's paper copy care plan found in the "Care Plan Binder" on the care area nursing station. Two of the three hand written notes were crossed off, and another hand written note was added to the side of the transferring section and signed.

The Inspector requested to see past paper copy care plans with the hand written update notes for the identified resident. The RAI Coordinator stated that they would not be able to provide the Inspector these documents as they were shredded after each quarterly care plan review when the most recent update notes were added to the electronic care plan.

Review of an identified resident's care plan found in the "Care Plan Binder" at the care area nursing station had only one copy of the resident's paper copy care plan. When asked if the Inspector would be able to obtain a copy of past paper care plan documents, with the hand written updates, the RAI Coordinator stated that they would not be able to provide the Inspector these documents. The RAI Coordinator stated the documents were

shredded after each quarterly care plan review, when the most recent update notes were added to the electronic care plan.

Review of two other identified resident's care plans found in the "Care Plan Binder" at the care area nursing station had only one copy of the resident's paper copy care plan. When asked if the Inspector would be able to obtain copies of past paper care plan documents, with the hand written updates, the RAI Coordinator stated that they would not be able to provide the Inspector these documents. The RAI Coordinator stated the documents were shredded after each quarterly care plan review, when the most recent update notes were added to the electronic care plan.

The licensee had failed to ensure that the records of identified resident's hand written, signed, care plan documents were kept at the home. [s. 232.]

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 records of the residents of the home are kept at the home, to be implemented voluntarily.

Issued on this 4th day of January, 2019

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

Original report signed by the inspector.