Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Oct 19, 2020	2020_790730_0017	015956-20	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

CHRISTINA LEGOUFFE (730)

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): October 13, 14, and 15, 2020.

The following intake was completed in this Critical Incident System (CIS) inspection: Log #015956-20, CIS #M627-000013-20 was related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, an Assistant Director of Care (ADOC), a Personal Support Worker (PSW), a Registered Practical Nurse (RPN), Registered Nurses (RNs) and a Clinical Support Nurse (CSN).

During the course of the inspection, the inspector observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

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

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

- **2 WN(s)**
- **2 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plans of care for residents #001 and #002 provided clear direction for the use of restraints.

Resident #001 had a physician's order for a restraint. A review of resident #001's hard copy plan of care on the unit included a hand written note that there was an order for a restraint, as needed. The electronic plan of care had not been updated regarding restraints. A Registered Nurse (RN) said that the plan of care did not provide clear direction for staff with regards to when the restraint was needed and that the plan of care should have been updated. A Clinical Support Nurse (CSN) said that resident #001's plan of care did not outline the goal that the care was intended to achieve related to restraints. They also said that resident #001's plan of care did not provide clear direction to staff with regards to when to apply the restraint and that there were not currently any other areas of the resident's plan of care that would provide additional direction.

Resident #002 was identified during an interview with a Clinical Support Nurse (CSN) as a resident who used a restraint. Resident #002 had a physician's order for a restraint. A Registered Nurse (RN) said that resident #002 used a restraint. The resident's electronic and hard copy plan of care in the care plan book on the unit did not include all restraints. A hard copy of the resident's care plan in the resident's paper chart included a hand-written note, which included all restraints used. An RN said that the information regarding

all restraints that resident #002 used should have been included on the newest version of resident #002's plan of care and should include more information with regards to when to apply the restraints.

There was an increased risk to the residents as their plans of care did not provide clear direction with regards to the restraint's direction for use.

Sources: Clinical records reviewed for residents #001 and #002 including orders, "Restraint Assessment Forms," and care plans; and interviews with staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plans of care for residents #001 and #002 were reviewed and revised when their care needs for falls prevention and management changed.

Resident #001 was admitted to hospital after a fall, resulting in an injury. Clinical records indicated that resident had interventions related to falls prevention and management. The resident's electronic and hard copy care plan did not include some of these interventions. A Registered Nurse said it was an expectation in the home that when a resident's care needs changed that the care plan would be updated immediately. Resident #001's care plan was not updated with regards to falls prevention interventions.

Resident #002 was identified during an interview with a Clinical Support Nurse (CSN) as a resident who was at high risk for falls. Clinical records indicated that resident #002 was to have interventions related to falls prevention. The resident's electronic and hard copy care plan did not include all of the interventions. One of the interventions had been hand written in on a paper care plan and dated. An RN said that resident #002's care plan was not updated with regards to falls prevention as per their expectations. The CSN said that the hand written intervention should have been added sooner as it had been part of resident' #002 plan of care for several months prior to that date.

There was an increased risk to the residents as their plans of care related to falls prevention were not reviewed and revised when their care needs changed.

Sources: Clinical records reviewed for residents #001 and #002 including progress notes, "Strathmere Lodge Bed Safety Assessment," care plans; observations of resident #001 and #002; and interviews with staff. [s. 6. (10) (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 resident plans of care are reviewed and revised when a resident's care needs change with regards to falls prevention and that resident plans of care provide clear direction for the use of restraints, to be implemented voluntarily.

WN #2: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident received a skin assessment upon return from hospital.

A resident was admitted to hospital, had surgery, and was readmitted to the home. The clinical record for the resident did not include a skin assessment after their return from hospital. The Assistant Director of Care said that it was their expectation that a skin assessment was completed for the resident after their return from hospital. This assessment was to be documented on a paper assessment tool titled “Skin Assessment,” but was not completed.

The home’s policy titled “Skin Care and Wound Management Manual” stated that all residents should have a skin assessment completed upon readmission following hospitalization.

There was an increased risk to a resident when they did not receive a skin assessment upon readmission from hospital.

Sources: Resident clinical record including progress notes, hospital records, paper chart, the home’s policy titled “Skin Care and Wound Management Manual"; and interviews with Assistant Director of Care and other staff. [s. 50. (2) (a) (ii)]

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 skin assessment is completed when a resident is readmitted from hospital, to be implemented voluntarily.

Issued on this 20th day of October, 2020

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

Original report signed by the inspector.