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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 9, 2014	2014_183135_0019	L-000093-14	Critical Incident System

Licensee/Titulaire de permis

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

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

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

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

BONNIE MACDONALD (135)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 7, 2014.

During the course of the inspection, the inspector(s) spoke with Administrator, RAI Coordinator, Clinical Support Nurse, Restorative Care Coordinator, Registered Nurse, Registered Practical Nurse, Physiotherapist, 4 Personal Support Workers, Health Care Aide and Resident.

During the course of the inspection, the inspector(s) reviewed resident clinical records and policy and procedures for Falls prevention. Observed resident care and services provided in resident home area.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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).

Findings/Faits saillants :

1. The Licensee failed to ensure that the plan of care set out clear directions for staff and others who provide direct care to the resident as evidenced by the following:

Resident #01 at high risk for falls was using a Broda chair.

In review of the resident's plan of care, the interventions for locomotion on the unit and falls prevention state the following:

-Total assistance on unit for safety reasons resident is sitting in a Broda chair.
-Staff is to ensure that resident is using rollator walker at all times to ambulate.

April 7, 2014, resident was observed seated in a tilt wheelchair.

In interview with the Restorative Care Coordinator she confirmed resident had been re-assessed and the resident has been using a tilt wheelchair.

The Acting Director of Resident Care confirmed the resident's plan of care did not provide clear direction for staff when the care plan had not been updated related to the resident now using a tilt wheelchair.to ambulate. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring plans of care provide clear direction for staff related to the resident's mobility devices, to be implemented voluntarily.

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

Findings/Faits saillants :

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

Resident #01 at high risk for falls was assessed to be trialled with non-skid socks as an intervention to reduce the number of falls.

April 7, 2013, resident was observed not wearing non-skid socks. Staff confirmed that resident had been wearing the non skid socks in the past.

Record review with the Clinical Support Nurse revealed there was no documentation related to the resident's response to the intervention of non-skid socks or if they had been discontinued.

The Acting Director of Resident Care confirmed her expectation that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that any actions taken with respect to a resident under a program i.e. resident's responses to interventions are documented, to be implemented voluntarily.

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Issued on this 9th day of April, 2014

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

Bonnie MacDonald