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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Jun 9, 2014	2014_183135_0032	L-000060-14	Follow up

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 Follow up inspection.

This inspection was conducted on the following date(s): May 8-9, 2014.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care, Clinical Support Nurse, RAI Coordinator, Facilities Manager, Registered Nurse, 2 Registered Practical Nurses, Personal Support Worker and 2 Health Care Aides.

During the course of the inspection, the inspector(s) reviewed resident bed systems and policy and procedures for Bed Safety and staff training related to bed safety.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that where bed rails are used, that the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On January 21, 2014, a compliance order was issued at the home for O.Reg.79/10, s.15.1 (a) for resident bed safety systems that was to be complied with by February 28, 2014.

Following that order the home commissioned an external contractor to complete a bed entrapment zone audit of all the resident's bed systems; that audit was provided to the home January 27, 2014.

The results of the Entrapment Mitigation Summary audit concluded that 78 (48.7%) of the beds failed one or more zones of entrapment which could potentially cause injury to the resident.

As of May 9, 2014, the home had not instituted their February 24, 2014, plan of correction when a record review with the Clinical Support Nurse, revealed that 71 (91%) of the 78 beds that failed one or more zones of entrapment had not been fully assessed using the home's Bed Safety Analysis document developed February 4, 2014.

During an interview the Administrator confirmed, his expectations that residents be assessed and his or her bed system evaluated in accordance with evidence-based

practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

2. The Licensee failed to ensure where bed rails are used, that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment when the following occurred:

On January 21, 2014, a compliance order was issued at the home for O.Reg.79/10, s.15.1(b) for resident bed safety systems, that was to be complied with by February 28, 2014.

The home commissioned an external contractor to complete a bed entrapment zone audit of all the resident's bed systems that was provided to the home January 27, 2014.

The results of the audit (Entrapment Mitigation Summary) concluded that 78 (48.7%) of the beds failed one or more zones of entrapment which could potentially cause injury to the resident.

1. During a tour of the home May 8, 2014, with the Registered Nurse, 36 of the 78 beds that failed one or more zones of entrapment were reviewed to determine if the home had put in place the mitigation strategies/interventions for residents as identified in the Entrapment Mitigation Summary, January 27, 2014.

The following 10 residents or 27.7 % of those reviewed during the tour, did not have interventions in place as per the audit.

#01-missing 1 gap filler, bed failed zones 2, 4, 7.
#02-missing 1 gap filler, bed failed zones 2, 4.
#03-missing rolled towels and wedges in gaps.
#04-missing 1 gap filler, failed zones 2, 4.
#05-bed rail to be tied down, tie had been cut and gap filler was missing from the bed.
#06-bed rail not tied down, bed failed zones 2, 4.
#07-no gap filler, failed zones 2, 4, 7.
#08-rolled towels to be in gaps. No towels observed on left side gap between mattress and rail.
#09-bed rail was not tied down as bed failed zones 2,4.

#10-missing rolled towels in gaps between mattress and bed rail.

2. The home's plan of correction states resident care plans will be updated including what interventions were to be put in place by February 28, 2014. In an interview with the RAI Coordinator, May 8, 2014, she confirmed that the care plans for the 78 residents whose beds failed one or more zones of entrapment had not been updated.

3. The home's Quality Improvement Plan for compliance states, as of February 13, 2014, all Personal Support Workers (PSW's) and Registered staff members are now educated in entrapment issues, zones of entrapment and mitigation strategies.

Record review with the Clinical Support Nurse May 9, 2014, revealed, 53 (38.4%)of 138 Registered staff had completed the training.

During an interview with a staff member when queried by the inspector as to what is the bed bolster system for bed safety, she stated "I have never heard of it. I know we have a couple of beds with the rails tied down. Some have been taken off by families."

During an interview the Administrator confirmed, his expectations that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 9th day of June, 2014

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

Bonnie MacDonald

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BONNIE MACDONALD (135)
Inspection No. / No de l'inspection :	2014_183135_0032
Log No. / Registre no:	L-000060-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 9, 2014
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

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

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:

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_183135_0004, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure the following where bed rails are used:

1. The resident has a complete assessment of their bed system using the home's Bed Safety Analysis document. Resident's bed systems are evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

2. Once Bed Safety Analysis is completed resident's Care Plans will be updated to reflect any resident entrapment zones and mitigation strategies/interventions required. Care plans will be amended quarterly and when there is significant change in resident's condition related to their bed system.

3. Steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

4. Ensure that all registered and non registered staff have been trained on the home's Bed Safety-Prevention of Entrapment policy NMBO12, January 23, 2014.

Grounds / Motifs :

1. The Licensee failed to ensure that where bed rails are used, that the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On January 21, 2014, a compliance order was issued at the home for O.Reg.79/10, s.15.1 (a) for resident bed safety systems that was to be complied with by February 28, 2014.

Following that order the home commissioned an external contractor to complete a bed entrapment zone audit of all the resident's bed systems; that audit was provided to the home January 27, 2014.

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During an interview the Administrator confirmed, his expectations that residents be assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.
(135)

2. The Licensee failed to ensure where bed rails are used, that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment when the following occurred:

On January 21, 2014, a compliance order was issued at the home for O.Reg.79/10, s.15.1(b) for resident bed safety systems, that was to be complied with by February 28, 2014.

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During an interview the Administrator confirmed, his expectations that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

(135)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2014

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.

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

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 9th day of June, 2014

Signature of Inspector / Signature de l'inspecteur : Bonnie MacDonald

Name of Inspector / Nom de l'inspecteur : BONNIE MACDONALD

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