Committee of the Whole

Meeting Date: November 9, 2021

Submitted by: Brent Kerwin, Administrator, Strathmere Lodge

SUBJECT: MINISTRY OF LONG TERM CARE COMPLIANCE INSPECTION VISIT

BACKGROUND:

The Lodge received the Public Copy of its inspection report on October 21, 2021 (attached).

During the course of six (6) days (i.e., September 23-24, September 27-29 and October 1), up to two (2) Compliance Inspectors from the Ministry of Long Term Care ("The Ministry") visited The Lodge daily in order to conduct an inspection of The Lodge's Infection Prevention and Control (IPAC) protocols, and four (4) "Critical Incidents" (2 resident hospitalizations resulting from a fracture, 1 incident of resident-to-resident abuse, and 1 incident of a narcotic not delivered to The Lodge by its pharmacy provider), further to The Lodge's submission of 4 Critical Incident Reports to the Ministry during the period May – September 2021.

As per provincial Long Term Care Homes legislation, homes must file Critical Incident reports with The Ministry for various incidents, including: a report of abuse; a missing resident; a missing or unaccounted for controlled substance (e.g., narcotic); an unexpected or sudden death; or an incident causing injury to a resident (e.g., fall with fracture) requiring a hospital visit and resulting in a significant health status change. The Ministry will review/investigate such incident reports.

Inspection reports are posted at The Lodge as required by provincial long term care homes legislation. Inspection reports are reviewed at meetings of The Lodge's Residents' Council and Family Council. The Ministry posts home inspection reports on its provincial Public Reporting website.

ANALYSIS:

The Lodge received a single finding of non-compliance to provincial long term care homes legislation for not strictly adhering to its policy on conducting Post-fall Head

Injury Assessments, to be performed by staff at nine (9) regular intervals over the first 48 hours following a resident fall (where a resident is witnessed to have hit his/her head, or may have hit his/her head as a result of an unwitnessed fall).

Specifically, inspectors identified 2 resident falls where the 2 applicable residents were not awaken from their sleep in order to perform a head injury assessment (which includes taking vital signs and ensuring pupils are reactive) at the required interval.

To minimize the possibility of a similar finding in the future, a member of the Nursing department will be assigned to regularly review all resident head injury assessment records to ensure that assessments are conducted/documented for all nine (9) intervals comprising a 48-hour head injury assessment routine.

Attachment

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

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 14, 2021	2021_777731_0023	007974-21, 010137-21, 013892-21, 013968-21	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

KRISTEN MURRAY (731), MEAGAN MCGREGOR (721)

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): September 23, 24, 27, 28, 29, and October 1, 2021.

The following Critical Incident intakes were completed within this inspection:

Related to responsive behaviours:
Critical Incident Log #007974-21 / CI M627-000011-21

Related to falls prevention:
Critical Incident Log #010137-21 / CI M627-000012-21

Related to an incident resulting in injury:
Critical Incident Log #013892-21 / CI M627-000017-21

Related to medication administration:
Critical Incident Log #013968-21 / CI M627-000018-21

An IPAC inspection was also completed at the time of this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), Registered Nurses (RNs), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), a Housekeeper, and residents.

The inspectors also observed resident rooms and common areas, observed snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the home's investigation notes, and reviewed medication incidents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the policies related to falls management and head injury assessment were complied with, for two residents.

O. Reg. 79/10 s. 48 (1) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10 s. 49 (1) requires that the program provides strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's policies and procedures "Resident Accident/Injury - Reporting Policy", last reviewed June 2019 and "Resident Accident/Incident - Head Injury Assessment Routine", last reviewed February 2018.

The resident injury reporting policy, and head injury routine (HIR) assessment policy required staff to complete a HIR assessment for every resident who had a fall with head injury and every resident who had an unwitnessed fall.

A resident sustained multiple unwitnessed falls and the HIR had sections of the assessments that were incomplete and stated the resident was sleeping.

A resident sustained an unwitnessed fall and a HIR assessment was initiated. One of the assessment sections was not completed, which indicated the resident was sleeping.

The Director of Resident Care stated that the expectation in the home was that staff completed the HIR for residents who had sustained unwitnessed falls and the staff should have attempted to wake a resident if they were sleeping to complete the sections of the HIR. There was minimal risk to the residents, related to the HIR assessments not being completed.

Sources: "Resident Accident/Injury – Reporting Policy", number NMR002 (last reviewed 2019/06/07), "Resident Accident/Incident - Head Injury Assessment Routine", number NMR004 (last reviewed 2018/02/27); two residents' progress notes and HIR assessments; and interviews with the DRC and other staff. [s. 8. (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 policies related to falls management and head injury assessment are complied with, to be implemented voluntarily.

Issued on this 15th day of October, 2021

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

Original report signed by the inspector.