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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 21, 2015	2015_325568_0001	L-001689-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
595 9th Avenue East OWEN SOUND ON N4K 3E3

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

LEE MANOR HOME
875 SIXTH STREET EAST OWEN SOUND ON N4K 5W5

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

DOROTHY GINTHER (568), JUNE OSBORN (105), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 6, 7, 8, 9, 12, 13, 2014

Critical Incident inspections for log# 002900-14, 009330-14, and 005976-14 were conducted in conjunction with the RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Resident Family Services Manager, Maintenance Lead Hand, 1 Registered Nurse, 5 Registered Practical Nurses, 10 Personal Support Workers,1 Recreation Aide, 1 Dietary Aide, 2 Environmental Services - Housekeeping staff, Resident Council representative, Family Council representative, Residents and Families.

The Inspector also conducted a tour of resident care areas on the second floor and common areas; observd residents and care provided to them, observed meal service, medication passes, medication storage areas; reviewed health care rcords and plan of care for identified residents; reviewed policies and procedures of the home, minutes of meetings and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours

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

- **3 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	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. 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 failed to ensure that 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 is complied with.

During resident interviews in stage 1 of the Resident Quality Inspection the following clothing items were reported missing and had not been found:
a) Resident #3 reported that they had two items go missing and they had not heard back from anyone.
b) Resident #14 shared that they had reported an item of clothing missing to staff. This item was similar to another that went missing a few months ago.
c) Resident #28 told staff that two items of clothing had gone missing in the last month and they have not been returned.
d) Resident #2 reported one piece of clothing missing and it had not been found.

The Home's Policy # XII-K-20.50 for Missing Resident Laundry revised April 2011 outlined the following procedure for PSW's:
1. Ensure that the Missing Laundry Form (XII-K-20.50(a)) is made readily available to families in each home area.
2. Assist the resident/family in completion of this form when an item is reported missing.
3. Conduct a search of the resident room and area for lost clothing.
4. Report the lost item by forwarding the Missing Laundry Form to the laundry staff if the item is not found in the home area.

Interview with two Personal Support Workers and a Registered staff revealed that when a resident reports a missing clothing item they will call the laundry department to inform them of the lost clothing. In addition, they will check the resident's room and surrounding area for the item. When asked if there was any kind of documentation they were required to complete related to the lost item, they indicated that they were not aware of anything.

Record review revealed that there were no Missing Laundry forms completed for the missing items reported by Resident #3, #14, #28 and #2. The Administrator confirmed that it is the staff's responsibility to ensure that a Missing Laundry form is completed when a resident reports a clothing item missing. The licensee failed to comply with the home's procedure for Missing Resident Laundry. [s. 8. (1) (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 the policy and procedure for lost resident laundry is complied with., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the actions taken to meet the needs of the resident with responsive behaviors include:
assessment
reassessments
interventions, and
documentation of the resident's responses to the interventions.

A Critical Incident submitted to the Ministry of Health and Long Term Care indicated that staff had witnessed an identified resident physically abusing other residents on several occasions. In all situations staff were able to intervene before anyone was injured.

The Director of Care revealed that the identified resident had a history of responsive behaviors and that these behaviors had escalated in the weeks prior to the incidents outlined in the Critical Incident. On a specified date the Minimum Data Set (MDS) assessment indicates that the identified resident exhibited the following behaviors on 1 to 3 of the last 7 days: wandering, verbally abusive, physically abusive, socially inappropriate / disruptive, and resists care.

Interview with the Director of Care revealed that it is the home's expectation that for residents that exhibit responsive behaviors a care plan is developed that includes specific strategies and interventions to respond to these behaviors. Personal Support Workers providing care for the resident take their direction from the Kardex which is derived from the care plan.

The Director of Care confirmed that the plan of care for the identified resident did not include a comprehensive interdisciplinary assessment of the resident's behavioral patterns and responsive behaviors. In addition, there were no documented interventions / strategies relating to the residents' identified responsive behaviors. [s. 53. (4) (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 , to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition and hydration program includes a weight monitoring system to measure and record with respect to each resident, their body mass index and height upon admission and annually thereafter, this is evidenced by:

During the staff interview portion of Stage 1 of the Resident Quality Inspection on January 6, 2015 it was noted that 17/40 residents did not have a current height in their record.

The Registered Practical Nurse verified that the height was not being taken on an annual basis.

The Director of Care confirmed that heights had not been done annually. Prior to completing the inspection the Director of Care provided a now completed list of heights taken January 8, 2015. [s. 68. (2) (e) (ii)]

Issued on this 22nd day of January, 2015

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

Original report signed by the inspector.