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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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

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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
Nov 10, 2016	2016_448155_0016	029189-16	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

SHARON PERRY (155), DOROTHY GINTHER (568), REBECCA DEWITTE (521)

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): October 18, 19 and 20, 2016.

The following intakes were completed within the Resident Quality Inspection (RQI):
001256-14 / CI M549-000012-14 related to fall prevention and management;
031919-15 / CI M549-000015-15 and M549-000016-15 related to a missing controlled substance;
and 029212-16 / CI M549-000009-16 related to fall prevention and management.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Resident and Family Services Manager, Assistant Director of Care, Clinical Documentation and Information Coordinator, Registered Practical Nurses, Personal Support Workers, Family Council representative, Resident Council representative, residents and families.

The inspectors also toured the home, observed medication administration, medication storage, reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information; observed the provision of resident care, resident-staff interactions, and observed the general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Skin and Wound Care
Sufficient Staffing

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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement.

Review of the registered staff schedule for the period of October 3, 2016 to October 19, 2016 revealed the following:
a) There were nine registered nurses on the staff schedule; two had just commenced orientation
b) During the seventeen day period there was no registered nurse who was an employee of the licensee on duty and present in the home as follows:
- nine out of seventeen night shifts (53 percent)
- four out of seventeen evening shifts (24 percent)
- two out of seventeen day shifts (12 percent).

On October 20, 2016, during an interview with the Administrator #100 and Director of Care #101 they acknowledged that the home did not have a registered nurse that was an employee of the licensee and a member of the regular nursing staff on duty and present in the home at all times. The Administrator #100 indicated that they had used the same agency nurse over the last couple of years to fill a number of the vacant shifts. In the last couple of months they have been successful in recruiting four new registered nurses. Three of these nurses have just begun their orientation to the home. [s. 8. (3)]

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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Review of resident #041's Minimum Data Set (MDS) quarterly assessment, revealed that the resident had altered skin integrity. Review of the progress notes revealed that

resident #041 had altered skin integrity.

During an interview with RPN #113 they shared that resident #041 was a risk for skin breakdown.

On October 20, 2016, during an interview, with the Clinical Documentation and Information Coordinator #115 they agreed that resident #041 was coded as having altered skin integrity and agreed that there was no skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On October 20, 2016, interview with the Director of Care #101 and the Assistant Director of Care #114 they shared that there was no skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment done for resident #041. They agreed that the expectation was that a skin and wound assessment should have been done for resident #041. [s. 50. (2) (b) (i)]

2. Review of resident #043's Minimum Data Set (MDS) quarterly assessment revealed that the resident had altered skin integrity.

During an interview with RPN #113 on October 20, 2016 they shared that resident #043 did not have areas of altered skin integrity at this time.

On October 20, 2016, during an interview, with the Clinical Documentation and Information Coordinator #115 they agreed that resident #043 was coded in their MDS quarterly assessment as having altered skin integrity and agreed that there was no skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On October 20, 2016, interview with the Director of Care #101 and the Assistant Director of Care #114 they shared that there was no skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment done for resident #043. They agreed that the expectation was that a skin and wound assessment should have been done for resident #043. [s. 50. (2) (b) (i)]

3. Review of resident #042's Minimum Data Set (MDS) annual assessment revealed that

the resident had altered skin integrity.

During an interview with RPN #110 on October 20, 2016 they shared that resident #042 was prone to having areas of altered skin integrity but did not have any at this time.

On October 20, 2016, during an interview, with the Clinical Documentation and Information Coordinator #115 they agreed that resident #042 was coded in their MDS annual assessment as having altered skin integrity and agreed that there was no skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

On October 20, 2016, interview with the Director of Care #101 and the Assistant Director of Care #114 they shared that there was no skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment done for resident #042. They agreed that the expectation was that a skin and wound assessment should have been done for resident #042. [s. 50. (2) (b) (i)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #3: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provisions of the care set out in the plan of care were documented.

A record review revealed there was no baths documented for resident #024 for the last thirty days.

During an interview with resident #024, they shared that staff bath/shower them on a weekly basis.

A review of the bathing schedule indicated that resident #024 was to be bathed/showered twice weekly.

An interview with RPN #113 revealed there was no documented record of baths/showers completed for resident #024. The RPN shared that baths/showers do get missed when the home was short of staff.

An interview with the DOC #101 revealed the provisions of care set out in the plan of care were not documented for resident #024. [s. 6. (9) 1.]

Issued on this 15th day of November, 2016

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

Original report signed by the inspector.