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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 22, 25, 2015	2015_253614_0014	014830-15	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

CAROLYN MCLEOD (614), DOROTHY GINTHER (568), 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): June 29, 30, July 2, 3, 6, 7, 8, 9, and 10, 2015.

When in the home the inspectors toured the resident home areas, medication room (s) and storage area(s), observed dining service, medication administration, provision of resident care, recreational activities, staff/resident interactions, infection prevention and control procedures, posting of required information, relevant policies and procedures as well as meeting minutes pertaining to the inspection.

During this inspection, the inspectors also inspected Critical Incident #M549-000002-15, with no findings of non-compliance.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Co-Director of Care, the RAI Coordinator, the Social Worker, the Environmental Services Manager, the Food Services Manager, the Registered Dietitian, Registered Staff, Personal Support Workers, Dietary Staff, Residents and Family Members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Sufficient Staffing

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

- **5 WN(s)**
- **5 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

An identified resident was observed during stage one of this inspection to have one bed rail up on the bed however the resident was not in bed. On a specific date, this resident was observed in bed and two bed rails were up. Review of the plan of care indicated that one bed rail was to be used when in bed.

Interviews with the resident and a Personal Support Worker (PSW) staff confirmed that the resident used two side rails when in bed.

Interview with the RAI Coordinator confirmed that staff were not providing care as specified in the plan of care as they were using two bed rails when the plan of care indicated that one bed rail was used. [s. 6. (7)]

2. The licensee has failed to ensure that when the resident was reassessed and the care plan was revised because the care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care.

According to the progress notes a specific resident had six falls during an identified time frame.

This resident was identified as a High Risk for falls.

The resident's plan of care for the time period identified revealed no change in the interventions regarding fall management.

During an interview with the Director of Care (DOC), it was confirmed that at the Resident Quality and Safety Management meetings, this resident was discussed. It was also confirmed that at this meeting alternative approaches were discussed but not implemented nor added to the care plan. [s. 6. (11) (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 that the care set out in the plan of care is provided to the resident as specified in their plan of care and that when the resident is reassessed that alternative approaches are considered, to be implemented voluntarily.

WN #2: 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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of the home's Fall Prevention and Management Policy VII-G-60.00, procedures section, refers to the home's Head Injury Routine as a component of the policy.

The home's policy VII-G-10.22 entitled Head Injury last modified September 2011 stated that any resident that may have sustained an injury to the head following a fall or impact with an object would be promptly assessed and have head injury routine initiated. As an un-witnessed head injury or neurological insult of unknown origin may cause changes in a resident's level of consciousness or responsiveness, all un-witnessed resident falls would be assessed for a potential head injury.

A) Record review revealed that a resident had un-witnessed falls over a period of time. Review of the resident's clinical record identified a head injury routine that was dated and a second head injury routine that was not dated.

The registered staff confirmed that head injury routines had not been completed for all of the resident un-witnessed falls.

B) Clinical record review revealed that another resident had an un-witnessed fall on a specific day. There was no documentation that a head injury routine was completed for the un-witnessed fall.

Registered staff confirmed that all un-witnessed falls should have a head injury routine completed and there was no documented head injury routine for that resident's fall.

Registered staff acknowledged that there was only one documented head injury routine which was not dated and a specific resident had four un-witnessed falls during an identified time period. [s. 8. (1) (a),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 that the home's policy VII-G-60.00 Fall Prevention and Management is complied with, which also includes the referenced policy VII-G-10.22 titled Head Injury, to be implemented voluntarily.

WN #3: 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 has failed to ensure that where bed rails were used the resident was assessed in accordance with prevailing practices to minimize the risk to the resident.

A) A specific resident was observed during stage one of this inspection to have one bed rail up on the bed however the resident was not in bed. On an identified date, this resident was observed in bed and two bed rails were up. Review of the plan of care indicated that this resident used one bed rail when in bed. Record review revealed that there was no documented assessment for the use of the bed rails for this specific resident.

Interview with the RPN-RAI Coordinator confirmed that this specific resident had not been assessed for the use of bed rails to minimize the risk to the resident.

B) Review of the plan of care revealed that an identified resident was to have two full bed rails raised when in bed for safety reasons.

Interview with a PSW revealed that this resident had two full bed rails raised when in bed. The staff member indicated that the resident would not be able to get out of bed with the bed rails raised however, if the bed rails were down they would be at risk of falling trying to get out of bed.

There was no documentation to indicate that this resident was assessed for the use of the bed rails and the RAI Coordinator confirmed that the home did not have an assessment for the use of bed rails. (568)

C) An identified resident was observed during stage one in bed with one quarter rail in the up position and one quarter rail in the transfer position. The resident was observed again on another date in their room, not in bed, with one quarter rail in the up position and one quarter rail in the transfer position.

Interviews with the Registered Nurse and the Personal Support Workers confirmed that the resident used one quarter rail and one transfer rail.

A review of the resident file revealed that there was no bed rail assessment for this resident. An interview with the RAI Coordinator confirmed this.(614)

D) A specific resident was interviewed during Stage 1 of this inspection. This resident stated that when in bed, the side rails on the bed were raised. Upon review of the resident file, there was no side rail assessment for this resident.

An interview with the home's RAI Coordinator, confirmed that the home did not conduct bed rail assessments for residents that utilize side rails; this did not mitigate risk with regard to resident safety.(614) [s. 15. (1) (a)]

2. The licensee has failed to ensure that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A review of the home's resident entrapment records, printed on a specific day, revealed that an identified bed belonging to a resident failed to pass entrapment guidelines in zone 6. This was confirmed by the RAI Coordinator.

An identified resident confirmed by interview that she used two full side rails in the up position when in bed sleeping.

The Administrator and the RAI Coordinator both confirmed by interview that while the home was planning to purchase new beds as well as bolsters in the immediate future, there were no interventions in place to mitigate risk regarding beds that fail entrapment testing at the time of inspection. [s. 15. (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 that where bed rails are used, that the resident has been assessed in accordance with prevailing practices to minimize the risk to the resident and that steps are taken to prevent resident entrapment taking into consideration all zones of entrapment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The MDS admission assessment for an identified resident indicated that the resident was continent of both bowel and bladder. The MDS quarterly assessment identified that the resident's continence had changed.

Staff interview with two Personal Support Workers revealed that this resident continence had declined since admission to the home. They indicated that the resident was sometimes continent but other times incontinent, particularly at night. Staff toileted the resident when the resident asked and routinely at a specific time.

Clinical record review identified a Urinary & Bowel Continence Management Toileting Flow Chart for a resident on a specific date which identified that the resident was continent with complete control of bowel and bladder. There was no documented continence assessment following the resident's decline in urinary continence as identified by the quarterly MDS assessment.

The RAI Coordinator confirmed that this resident did not have a continence assessment completed following the change in continence identified by the MDS assessment. The staff member shared that the home had created a new continence assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, but it had not yet been implemented. [s. 51. (2) (a)]

2. The licensee failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan was implemented.

Review of the plan of care indicated that the care plan had not been updated to include an individualized plan to promote bladder continence. [s. 51. (2) (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 that residents that are incontinent receive an assessment of their incontinence using a clinically designed appropriate assessment instrument that has been specifically designed for incontinence assessment and that the resident has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status

Clinical record review identified a specific resident as a high nutritional risk. Monthly weights were recorded for this resident.

A significant weight change was identified.

Review of the home's policy # V-E-50.00 entitled Significant Changes in Weight indicated that resident's were to be weighed monthly and the weight was to be recorded in the resident's chart. If a resident has a weight gain or loss of 2 kg from the previous month then the resident was to be reweighed immediately and the second weight obtained was be recorded in the reweigh column of the weight record.

Registered Nursing staff would complete a Nutrition Manager/Dietitian Referral form if the resident had an actual weight loss or gain of 2 kg or more. The referral form would be sent to the Nutrition Department and the Nutrition Manager would assess if the resident was deemed a high nutritional risk for weight variance and refer the resident to the Registered Dietitian.

During interviews with the Nutrition Manager and Registered Dietitian (RD) they acknowledged that the specific resident had a weight change of more than 2 kg during a specific time period. They confirmed that no re-weighs were recorded for this time period, that a Nutrition Manager/Dietitian Referral was not completed, and the resident was not assessed by the RD with regards to the significant weight changes. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with weight changes are assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

Issued on this 2nd day of November, 2015

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

Original report signed by the inspector.