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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 5, 2019	2019_781729_0008	029154-17, 029444-18, 004287-19	Critical Incident System

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

KIM BYBERG (729)

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): May 15, 16, 21, 22, 23, 24, 27, 28 and 29, 2019.

Log #029154-17 related to missing or unaccounted for controlled substances, Log #004287-19 and Log #029444-18 related to an injury of a resident that resulted in the transfer to hospital with significant change in status.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Office Administrator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Social Worker (RSW), Resident Assessment Instrument Coordinator (RAI), Restorative Care Aide (RCA), Residents and Family members.

The inspector also observed resident rooms and common areas, residents and the care provided to them; reviewed health care records and plans of care for identified residents, and relevant policies and procedures of the home.

A Complaint Inspection #2019_781729_0009 was completed in conjunction with this inspection.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #005 was reassessed, and their plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A Critical Incident System (CIS) report submitted to the Ministry of Health and Long Term Care (MOHLTC) on a specified date, reported that resident #005 sustained an injury while being transferred with a specified assisted device.

While resident #005 was being transferred by two PSWs with a specified assisted device to a standing position, resident #005 showed signs of pain and told the PSWs about their injury.

A review of resident #005's plan of care indicated that they required assistance from one or two staff members, and staff were to provide weight bearing support for the transfer.

A review of the home's policy titled "Safe Resident Handling", current revision April 2019, stated that the nurse or delegate, would reassess residents and complete the electronic lift and transfer assessment when there was a change affecting the residents ability to transfer safely, and document in the progress notes when there was a change in transfer or lifting status. The physiotherapist would collaborate with the nurse in the assessment of the resident's lift and transfer status, complete further assessments as required to determine the most appropriate lift and transfer method and update the plan of care as required.

PSW #119 shared that they would look at the kardex for resident #005's plan of care interventions related to their transfer status. They shared that for a specified time prior to the incident, resident #005 was having trouble weight bearing and staff were using the

assisted device for transfers. PSW #119 stated that lift and transfer assessments were completed by either the physiotherapist, the nurse or the restorative care aide.

Restorative Care Aide (RCA) #117 shared that when a resident was not transferring as per their plan of care, the RPN would complete a referral to have the resident reassessed. RCA #117 stated that they, along with the physiotherapist would complete lift and transfer assessments, complete a progress note and update the plan of care with any changes.

A review of resident #005's progress notes did not show that a lift and transfer assessment had been completed, nor was there a referral completed to request an assessment when their transfer status changed.

DOC #102 shared that a referral to physiotherapy and a reassessment should have been completed for resident #005, when it was noted that they were having difficulty with weight bearing, which required an assisted device to complete their transfer. [s. 6. (10) (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 each resident is reassessed and their plan of care revised when the resident's care needs change, to be implemented voluntarily.

Issued on this 6th day of June, 2019

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

Original report signed by the inspector.