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**

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## 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 |
|---|---|---|---|
| Feb 6, 2020 | 2020_836766_0003 | 018737-19, 018738-19, 018739-19, 022013-19 | Complaint |

## 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

KATY HARRISON (766), KIM BYBERG (729)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): January 27,28,29,30 and 31, 2020.**

**The following intakes were completed in this Complaint inspection:**
**Log #022013-19, Complaint related to Pain Management;**
**Log #018737-19, Follow-up (FU) to CO #001 from inspection #2019_787640_0024 related to plan of care;**
**Log #018738-19, FU to CO #002 from inspection #2019_787640_0024 related to fall prevention policy;**
**Log #018739-19, FU to CO #003 from inspection #2019_787640_0024 related to fall prevention.**

**During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate DOC (ADOC), Social Worker, Dietician, Registered Nurse (RN), Registered Practical Nurse (RPN), RAI Coordinator, Personal Support Workers (PSW), residents and families.**

**The inspectors also toured the residents' home areas, observed resident care provision, meal service, resident staff interaction; reviewed relevant residents' clinical records, relevant policies, procedures and staff training records pertaining to the inspection.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Falls Prevention**
**Medication**
**Nutrition and Hydration**
**Pain**

**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)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 49. (2) | CO #003 | 2019_787640_0024 | 729 |
| LTCHA, 2007 S.O. 2007, c.8 s. 6. (7) | CO #001 | 2019_787640_0024 | 729 |
| O.Reg 79/10 s. 8. (1) | CO #002 | 2019_787640_0024 | 729 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that resident #003 and resident #006 received end of life care in accordance with the directions specified by the prescriber.

a) A complaint was submitted to the Ministry of LTC (MLTC) on a specified date, related to care concerns of resident #003.

A physician's order on a specified date stated that resident #003 was to receive end of life care. The electronic medication Administration Record (eMAR) for resident #003 showed a physician’s order for an intervention to administer medication. The order read; to complete the intervention every three days. The home did not complete the intervention for six days.

The DOC and RPN #105 shared that the intervention should have occurred every three days.

b) An end of life care order was received from the physician on a specified date for a prescribed intervention and to administer medication. The order read; to complete the intervention every three days.

On a specified date resident #006's progress notes stated that the intervention was completed. There was no further documentation for the next five days to indicate that the intervention had taken place.

RN #112 and ADOC #101 shared that the home's policy was to to complete the intervention every three days, it would be documented in the progress notes and in the eMAR. ADOC #101 shared that it was the responsibility of the registered staff to enter the intervention into the eMAR and create a rotating schedule for the intervention to be completed every three days. They shared that this process was not implemented for resident #006.

The licensee failed to ensure that resident #003 and resident #006 received end of life care in accordance with the directions for use specified by the prescriber. [s. 42.]

***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 every resident receives end-of-life care when required in a manner that meets their needs, to be implemented voluntarily.***

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**Issued on this 7th day of February, 2020**

[redacted]

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

**Original report signed by the inspector.**