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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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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
Aug 26, 2021	2021_823653_0021	005180-21, 007901-21, 008609-21, 011612-21	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

ROMELA VILLASPIR (653), TAWNIE URBANSKI (754)

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): August 9-13, 16-17, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log #005180-21 was related to an allegation of physical abuse;
Log #007901-21 was related to an injury from unknown cause;
Log #008609-21 was related to transferring techniques;
Log #011612-21 was related to controlled substance.

NOTE: A Written Notification and a Voluntary Plan of Correction related to O. Reg. 79/10, s. 36 was identified in this inspection and has been issued in a concurrent inspection, #2021_823653_0020, dated August 26, 2021.

During the course of the inspection, the inspector(s) spoke with the residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), Behavioural Support Ontario (BSO) RN, Assistant Director of Care (ADOC), Interim Building Services Supervisor (iBSS), and the Director of Care (DOC).

During the course of the inspection, the inspectors toured the home, observed provision of care, resident to resident interaction, reviewed clinical health records, air temperature records, staffing schedules, medication incident report, analysis, and quarterly review, the home's investigation notes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was protected from abuse.

An incident occurred between two residents which resulted in physical injuries to one resident.

Sources: Critical Incident System (CIS) report, residents' clinical records, and interviews with the Director of Care (DOC) and Behavioural Support Ontario (BSO) Registered Nurse (RN). [s. 19. (1)]

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 are protected from abuse by anyone, and ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the air temperature was measured and documented in writing, in at least one resident common area on every floor of the home, and two resident bedrooms in different parts of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, and that a record of the measurements were kept.

As of May 15, 2021, Ontario Regulation (O. Reg.) 79/10 included additional amendments related to cooling requirements and air temperatures in the Long-Term Care (LTC) home.

A review of temperature records was completed for each floor at Lee Manor from July 29, 2021, to August 10, 2021.

From July 29, to August 10, 2021, the air temperature of two resident bedrooms in different areas of the home and at least one common area on every floor was not always measured nor recorded at the required specified times.

The Interim Building Services Supervisor (iBSS) agreed that two resident bedrooms in different areas of the home and at least one common area on every floor of the home was not always measured and recorded at the required specified times.

By not measuring and documenting air temperatures of the home, as required, the home would be unable to identify when a temperature related concern occurs. This may have put residents at risk for a temperature related illness.

Sources: Record of the home’s documented air temperatures, and an interview with the iBSS. [s. 21. (2) 1.]

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 temperature is measured and documented in writing, at a minimum in the following areas of the home: 1. At least two resident bedrooms in different parts of the home. 2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. 3. Every designated cooling area, if there are any in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

The home had submitted a CIS report related to a resident's unaccounted drug. The resident had an order for the drug to be administered at a specified time. At the time of the incident, the tablet fell into the drawer of the medication cart after the Registered Practical Nurse (RPN) had taken it out from the blister pack. A thorough search was completed by three RPNs, however, the tablet was not found. The two RPNs stated that when they re-approached the resident, the resident was already sleeping, so they did not take out another tablet to offer to the resident. Both registered staff confirmed that the resident did not receive their scheduled drug. The Assistant Director of Care (ADOC) stated that the expectation was to prepare the tablet and offer it to the resident. The resident may have been put at risk for experiencing pain and discomfort due to not receiving their scheduled drug.

Sources: CIS report, resident's physician medication review, medication incident report & analysis form, eMAR, progress notes; Interviews with the RPNs, and the ADOC. [s. 131. (2)]

Issued on this 27th day of August, 2021

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

Original report signed by the inspector.