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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 17, 2013	2013_225126_0007	O-000098-13, 000150,000151-13	Complaint

Licensee/Titulaire de permis

NEW ORCHARD LODGE LIMITED
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE LAURIER MANOR
1715 MONTREAL ROAD, GLOUCESTER, ON, K1J-6N4

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

LINDA HARKINS (126)

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): March 21-22, 2013

During the course of the inspection, the inspector(s) spoke with Director of Care, the Assistant Director of Care, the Environmental Manager, several Registered Nurses, several Registered Practical Nurses, Personal Support Workers, two Housekeeping staff, Admission Clerk, several residents and family members.

During the course of the inspection, the inspector(s) reviewed several residents health care records, restraint policy and observes care and services given to residents.

During the course of this inspection 3 complaints were inspected.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Medication

Findings of Non-Compliance were found during this inspection.

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).

Findings/Faits saillants :

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1. The licensee failed to comply with LTCHA, 2007, S.O. 2007, c.8 S 6. (7) in that the home did not ensure that the care set out in the plan of care was provided to the resident as specified on the plan.

Resident #2 was admitted to the home on a specific day in February 2013 from a Hospital. Resident#2 required specific nursing and transfer equipment. [s. 6. (7)]

On a specific day in February 2013 during the conference with the team and the family it is documented in the progress notes that the family member had concerns because the nursing equipment was not applied properly and that some of the staff did not know how to use a specific transfer equipment safely. Resident#2 was admitted on a specific day in February 2013 and staff did not have the training on how to use the transfer equipment to transfer Resident #2 safely.

On a specific day in March 2013, family member was visiting Resident #2 and observed that the nursing equipment was not properly applied.The home did document to ensure the nursing equipment is applied properly at all times but some staff applied the nursing equipment inapp ropriately. [s. 6. (7)]

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 Resident #2's care needs related to the nursing equipment and transfer equipment is provided to resident including staff awareness on how to apply nursing equipment and that education is provided to staff related to transferring Resident #2 safely., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s.44 in that the the home did not ensure to have supplies, equipment and devices readily available at the home to meet the nursing and personal care needs of residents.

In October 2012, Resident #3 was known to be at high risk of falls. Resident #3 was being readmitted to the unit from the hospital with an injury repair from a fall that occurred in October 2012. Resident #3's family member requested to have 2 full bed rails up when resident was in bed. Documentation in the progress note indicated that S# 100 told the resident's family member that they didn't have a bed with full rails available since another resident was using it. S# 100 was going to follow up. Progress note was reviewed for one week following the family member's request and no documentation was found related to the application and/or the assessment of the needs for utilization of full bed rails for Resident # 3. [s. 44.]

2. Resident #2 was admitted to the home on a specific date in February 2013. The day following the admission, the progress note indicated that Resident #2's family member requested that the Resident have full bed rails on the bed. Resident #2 fell out of bed on three occasions in a period of 6 days in February 2013 resulting in no injury. On another occasion, the resident's family member inquired if portable bed rails could be a possibility. On a specific date in February 2013, staff #102 wrote in the progress notes that " still looking for the bed with 1/2 bed rails". On a specific date in February 2013, during a conference with the team and the Resident's family member, discussion was held regarding the utilization of full bed rails. The bed with full bed rails was transferred to the resident room's after the meeting. The bed with full bed rails had manual crank therefore did not allow the Resident to adjust independently or to change his/her positioning. During the course of the inspection on March 20 and 21, 2013 Resident #2 was observed to be resting in a manual bed with one side rail up. Resident #2 indicated that if he/she wishes to reposition himself/herself he/she is required to use the call bed and cannot do it independently.

On a specific date in February 2013 during the conference held for Resident #2, with the team and the family it was documented in the progress notes that the family member has concerns because the nursing equipment was not properly applied. On several occasions, Resident #2 requested to have the nursing equipment changed and was told that it was ordered.Resident #2 nursing equipment was not changed for 4 days because it was not available.

On a specific date in March 2013, family member was visiting Resident #2 and observed that the nursing equipment was not appropriately applied. The specific nursing supply has not been available for several days to meet Resident #2 needs. [s. 44.]

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 supplies such as nursing equipment and equipment such as beds and bed rails are readily available at the home to meet the nursing and personal care needs of the residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 87 (2) (d) in that the home has failed to address offensive and lingering odours in a resident's washroom.

On March 21 and 22, 2013 during the course of the inspection it was noted by Inspector #126 that each day there was a strong urine-like smell that was evident in Resident #2's washroom, despite the washroom appearing being clean and tidy. The Environmental Manager was brought to the resident's washroom on March 22, 2013 and confirmed that there was a strong urine-like smell odours in the washroom. [s. 87. (2) (d)]

2. On March 21, 2013, during the course of this inspection, Inspector #126 noted a smell of urine when getting out of the elevator on the third floor. [s. 87. (2) (d)]

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 offensive and lingering odours are addressed in the resident bathrooms and on the third floor., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.15. (2) (a) in that the home has failed to ensure that the floors are kept clean.

On March 21 and 22, 2013 it was observed by Inspector # 126 that the floor in the common area outside the elevator was noted to have dried dirt.
On March 22, 2013, the Environmental Manager came to the unit with Inspector #126 and observed the dried dirt on the floor. He indicated that he would address this with his housekeeping staff to ensure the floors are clean properly. [s. 15. (2) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10 s.134. (b) in that the home did not ensure that appropriate actions were taken to monitor the resident response to a pain medication and monitor for potential adverse reaction. [s. 134. (b)]

2. On a specific date in February 2013, Resident #2's pain medication was discontinued and was ordered another type of pain medication. The Physician, wrote in the order," I am aware of a specific type of pain medication allergy." . S# 101 wrote in the progress note of a specific date in February 2013, " Resident started on new RX of pain medication Physician aware of allergy Hosp. papers states hallucinates under allergy note -to monitor."

Progress notes reviewed for the specific date in February 2013, no documentation related to resident condition on becoming more confused or monitoring of adverse reaction. Three days after starting the pain medication it is documented in the progress notes, that the family member expressed concerns because resident #2 was more confused since he/she started that new pain medication and has had reaction in the past to a similar pain medication. The family member insisted that the resident be switched back to the original pain medication.
The evening the medication was discontinued, Resident #2 fell out of bed twice without any injury. [s. 134. (b)]

Issued on this 25th day of June, 2013

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