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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 27, 2015	2015_295556_0005	O-001546-15	Resident Quality Inspection

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

WENDY PATTERSON (556), LISA KLUKE (547), LYNE DUCHESNE (117), PAULA MACDONALD (138)

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): February 9, 10, 11, 12, 13, 17, 18, 19, 20, 2015

Additional logs inspected during the RQI: O-001519-15, O-000424-14, O-001533-15, O-001637-15

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director's of Care (ADOC), Registered Dietitian (RD), Social Worker (SW), Support Services Manager (SSM), Dietary Services Manager (DSM), Food Service Supervisor (FSS), Food Service Workers (FSW), Registered Nurses (RN), Registered Practical Nurses (RPN's), Maintenance Worker, Housekeeping Staff, Resident Program Manager (RPM), Activity Aides, President of the Resident's Council, Family Council Representative, Personal Support Workers (PSW), Residents, and Family Members.

The Inspectors toured resident and non-resident areas, observed several dining services, and medication administration, reviewed resident health care records, policies related to Resident Abuse, Medication Storage, Restraints and PSAD's, the home's Preventative Maintenance Schedule, Staff Training Records related to abuse, the home's Internal Investigation Documentation, internal Incident Report, and MOHLTC Critical Incident Reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **7 VPC(s)**
- **1 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 O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 10.(1) of the regulation in that the licensee failed to ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

Inspector #138 was on elevator #1 and observed a staff member access a service corridor on the ground floor via the rear door of the elevator by simply pressing the "door open" button without visibly accessing any mechanism to restrict access through the rear door of the elevator. The inspector returned to the same elevator mid-morning on February 17, 2015, and was able to call the elevator to the ground floor, hit the rear "door open" button which opened the rear elevator door and then was able to access the service corridor. The inspector toured the service corridor and noted that it contained a staff kitchen/lunch room, the main kitchen, the laundry room, several washrooms, an office, a locked electrical room, and a locked service door to the outside. The inspector further toured the staff kitchen/lunch room and observed access to a water dispensing machine with a hot water feature, no call bell, and several windows at ground level that opened fully to about three feet. Staff in the staff kitchen/lunch room stated to the inspector that the room was not locked and is always open for all shifts, days, evenings, and nights.

The inspector spoke with the Support Services Manager regarding the access to the service corridor through the rear elevator door. The Support Service Manager stated that residents are not to access the service corridor thus the locking mechanism on the double doors directly beside the elevator leading to the service corridor. The Support Service Manager further stated that the locking mechanism for the rear elevator door was on by pass mode in order to allow staff to call the elevator from the service corridor. The Support Services Manager stated that it was impossible, due to the age of the elevator, to restrict access to the rear elevator door from the inside of the elevator while allowing staff to call the elevator from the service corridor. [s. 10. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 :

1. The licensee failed to comply with the legislation in that resident's written plan of care did not set out the planned care for the resident.

Resident #015 is identified as being at high risk of falls and is also an active wanderer. The resident utilizes a wheelchair that he/she self-propels to mobilize on the unit. On February 11, 12, 17 and 18, 2015, the resident was observed to have a lap belt and a wheelchair tab alarm. PSW staff members #113, #127 and #128 stated to Inspector #117 that Resident #015 is at high risk of falls as the resident tries to self-transfer in and out of bed, wheelchair or on to the toilet without assistance. They report that the lap belt, which the resident can undo, and the wheelchair tab alarm have been in place as fall prevention interventions for approximately the past year. They all stated that the lap belt and tab alarm are used and applied on a daily basis.

Resident #015's written plan of care, dated December 16 2014, was reviewed. No information was noted in the written plan of care related to use of the lap belt and tab alarm as fall prevention interventions. The written plan of care was reviewed with unit RN #116 and RPN #117 who both confirmed that resident's written plan of care did not identify the use and application of the wheelchair lap belt and tab alarm as fall prevention interventions for Resident #015. Both stated that these interventions have been in use on a daily basis and should be clearly identified in the resident's written plan of care. Resident #015's written plan of care did not identify the planned care as it relates to the use and application of a wheelchair lap belt and tab alarm as fall prevention interventions. [s. 6. (1) (a)]

2. Inspector #138 observed the breakfast and lunch meal service on second floor on February 17, 2015. During the observations it was noted that several residents were not provided nutritional care according to the meal roster. The home's Director of Care identified that the meal rosters located in the dining rooms were considered to be a part of the plan of care.

Specific observations included:

-Resident #002 is to receive a lactose restricted diet but received regular milk at both breakfast and lunch. The resident refused to drink the milk at both meals. The inspector spoke with the home's Registered Dietitian #124 who stated that the home's lactose restricted diet excludes regular milk and instead offers a lactose free milk.

-Resident #051 is also on a lactose restricted diet and the meal roster highlights absolutely no milk products. At lunch, the resident was provided a milk based soup and was given a dairy rich dessert (the non dairy dessert was not even offered to the resident). The inspector spoke with the home's Registered Dietitian #124 who stated that the resident is very sensitive to lactose found in milk and other dairy products and that the resident should not have been offered the dairy rich dessert. The Food Service Supervisor #125 stated to the inspector that there is always a supply of ready to serve, lactose free soups on each unit.

-Resident #054 is to receive a lactose restricted diet with thickened fluids. The resident was observed at breakfast to be offered an individual container of pre thickened milk beverage and then offered a second container of the pre thickened milk beverage. The inspector reviewed the container and noted that the beverage was not lactose free. The inspector spoke with Food Service Supervisor #125 who stated that the pre thickened milk beverage is not appropriate for Resident #054 and that other interventions would be required to meet the resident's nutritional needs.

-Resident #053 is to receive a vegetarian diet with soya milk at meals. The resident was observed at breakfast to receive regular milk. It was noted that soya milk was available. The resident was not offered any soy milk at lunch. [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 residents are provided nutritional care according to the meal rosters, to be implemented voluntarily.

WN #3: 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 section 15.(2)(a) in that the licensee failed to ensure that the dining room floors are kept clean and sanitary.

It was observed on February 9, 2015 by Inspector #547 that the dining room floors throughout the home appeared unclean during a walk thorough that occurred mid-morning. That same day, Inspector #138 also observed the dining room floor on second floor immediately prior to lunch was also unclean.

On February 17, 2015, Inspector #138 was on the second floor at breakfast and noted that there were spilt beverages, eggs, crumbs, and paper napkins on the floor at the end of the breakfast meal. The inspector returned to the dining room immediately prior to lunch and noted that the dining room floor had not been cleaned as the crumbs, food, napkins and spilt beverages remained. The inspector also toured the third, fourth and fifth dining room prior to lunch and noted that the floors were unclean and presented with food crumbs and debris, dried spills, empty food packaging, empty sugar packets, soda

cracker wrappers, and used napkins. Further, the inspector noted that the edges along the dining room floor on each of the floors had a black build up of grime and that the corners, especially near the serveries, had an even greater accumulation of grime and debris. It was also observed that the dining rooms are used as a lounge space outside of the meal service.

The inspector spoke with the Support Services Manager who reported that each floor has a housekeeping aid during the day and each housekeeping aide is to spot clean the dining room after breakfast with a full clean to be completed after lunch. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home was maintained in a safe condition and in a good state of repair.

On February 9, 2015 Inspector #547 conducted an initial tour of the resident care units, and noted the fourth floor West wing of the home to have sharp metal baseboard framing broken and protruding into the hallway posing a risk for injury to residents mobilizing in this hallway where resident rooms are located. Metal baseboard framing in the corner of the hallways near rooms #402, #405, and #418 were also noted to be cracked and broken providing sharp metal surfaces near ankle area for residents on this unit.

On this same date, during the initial tour of the fourth and fifth floor resident care areas Inspector #117 noted that in several areas, especially under the hallway hand sanitizer dispensers, the painted surface of the handrails to be removed and chipped, exposing the porous surface of the wood providing a surface that cannot be properly cleaned and sanitized.

On February 10, 2015 Inspector #138 noted the handrails in the hallways of the west wing of the second floor, near rooms #234, #235, and #219 that paint had been gouged with sharp edges along the railing.

On February 10, 2015 Inspector #547 noted in Resident shared room #435-1 the resident's bed was pushed against the wall where an outlet with wire coming out of the center was damaged and was located directly behind the left quarter rail of the bed. Resident #030 utilized this quarter rail regularly for repositioning while in the bed. It was further noted, that at the top left corner of this residents bed, near the pillow, there was a cable splitter with three cable wires that were no longer properly secured to the wall.

On February 11, 2015 Inspector #138 noted the handrails along the East wing of the third

floor to be worn and gouged in several areas, and loose near the utility room and tub/shower room.

On February 18, 2015 Inspector #547 along with the Support Services Manager (SSM) observed the metal baseboards on the West wing of the fourth floor resident unit where the baseboards were damaged and bent outward posing a risk for injury to residents mobilizing in this hallway. The SSM indicated that the metal baseboard framing had been an issue in the home, and that several corners and hallways had been repaired on the second floor, however he was not aware of these areas on the fourth floor until today. The Maintenance communication book on the fourth floor did not have any indication of this risk, and the SSM indicated that he had not seen this during his daily rounds of the units. The SSM indicated that he does not record areas for repair during his rounds, however will verify if the areas are indicated in the maintenance communication book, or will write them in for tracking. The SSM further indicated to Inspector #547 that the cable box and splitter in room #435-1 should have been repaired to prevent resident injury and the metal frames on the baseboards in the hallways should have been repaired as they pose a risk of injury to the residents on this unit. [s. 15. (2) (c)]

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 maintenance areas of risk to residents are reported and repaired immediately, and to ensure the dining room floors are cleaned according to the home's cleaning schedule, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The home failed to comply with section 17 (1)(b) of the regulation in that the licensee failed to ensure that the resident-staff communication and response system (commonly known as the call bell system) was on at all times.

On February 10, 2015, it was observed by the inspectors that the bedside call bell toggles did not function and thus were not on for resident rooms 332-1, 320-1, 435-1, and 517-1.

On February 12, 2015 it was observed again that the bedside call bell did not function, and thus not on, in room 320-1 and 517-1. [s. 17. (1) (b)]

2. The home failed to comply with section 17 (1)(f) of the regulation in that the licensee failed to ensure that the home's resident-staff communication and response system clearly indicates when activated where the signal is coming from.

The home has a resident-staff communication and response system that is commonly known as a call bell system in which a signal is initiated from the call bell pull cord, toggle, or station. Staff are alerted that a call bell has been initiated via a light outside the resident's room, a page that is sent to a pager carried by all home area PSWs,

RPNs, and the RN indicating the location the signal was activated, and an annunciator panel at the nursing station that displays the location the signal was activated.

On February 11, 2015, Inspector #138 tested the call bells in room 308, bed 1 and 2 as well as the shared washroom and noted that PSW #105 assigned to care for the residents in these two beds carried a pager that that did not display that a call bell signal was initiated from either bed or the washroom. PSW #105 stated that the pager was not functioning.

On February 10, 2015, Inspector #138 spoke with several PSWs on second floor regarding the pagers that are to be carried by the staff and three PSWs stated that they were not carrying a pager as the assigned pagers were missing. The inspector returned to the second floor on February 12, 2015, and asked staff regarding the pagers. All staff on second floor including RN #133 stated that all PSWs are to carry a pager. It was confirmed, however, by the inspector that two of the four pagers for 2 East were missing with no replacement. The missing pagers were identified as PSW3 and PSW4.

Discussion was held with both the Support Services Manager and the Assistant Director of Care #111 who both stated that the call bell system in the home has been redesigned to include pagers that are to be carried by all PSWs on the home areas as well as the RPNs and the RNs. [s. 17. (1) (f)]

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 1) all resident accessible call bell toggles/pull cords are operational and maintained in good repair at all times throughout the home; 2) the pagers used by PSWs to respond to an activated call bell are maintained in good working order at all times and; 3) the home has a system in place to ensure an adequate supply of pagers used by the PSWs as part of call bell system at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

As per Ontario Regulation 79/10 2. (1) sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A progress note stated that it was reported by Resident #047 that Resident #044 entered his/her room, walked straight to him/her, and grabbed a specific body part.

In an interview Resident #047 stated that he/she immediately reported the incident to the PSW and the Registered Nurse but after that nobody ever came back to talk about the incident.

In an interview RN #133 stated that when the incident happened she documented it in the progress notes but did not verbally report it to a manager. RN #133 further stated that she doesn't remember a manager ever coming to talk to her about the incident.

In an interview the ADOC stated that every morning she reviews the report from the previous 24 hours, which includes all progress notes, and follows up with the staff on the floor as necessary. She then reports anything out of the ordinary at the daily morning management meeting.

On February 17, 2015 in an interview the Administrator indicated to Inspector #556, and later that same day to Inspector #117, that the incident had been investigated and it was determined that it did not meet the definition of sexual abuse.

On February 20, 2015 the Administrator requested an interview with Inspector #556 stating that she wanted to provide additional information regarding the incident with Resident #047 where a resident entered another resident's room and grabbed Resident #047's specific body part. The Administrator stated that because they knew the residents involved the managers of the home did not interpret the incident as being sexual in nature and therefore they did not investigate the incident, nor did they report the incident to the MOHLTC. [s. 23. (1) (a)]

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 any alleged, suspected or witnessed incident meeting the definition of abuse of a resident as per O.Reg 2.(1)is immediately investigated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

As per Ontario Regulation 79/10 2. (1) sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

In the process of conducting a Resident Quality Inspection Resident #044's Health Care Record was reviewed and it was noted that a progress note stated that it was reported by Resident #047 that Resident #044 walked into his/her room while he/she was resting in bed and grabbed a specific body part. The note further stated that Resident #044's POA and MD was contacted.

In an interview Resident #047 stated that Resident #044 often wandered into his/her room and rummaged through the drawers or the closet, however, on a specific date Resident #044 came straight over to the bed and grabbed a specific body part in an intentional manner. Resident #047 stated that he/she immediately reported the incident to the PSW and the Registered Nurse but after that nobody ever came back to talk about the incident. Resident #047 stated that he/she felt sexually abused and felt afraid and didn't want to be in his/her room alone for a long time following the incident.

In an interview RN #133 stated that on the date of the incident she did not immediately report to anyone, she just charted it in the progress notes.

In an interview the ADOC stated that every morning she reviews the report from the previous 24 hours, which includes all progress notes, and follows up with the staff on the floor as necessary. She then reports anything out of the ordinary at the daily morning management meeting.

In an interview the Administrator and the Director of Care indicated that they knew about the incident and determined that it did not meet the definition of sexual abuse and therefore the home did not report the incident to the MOHLTC. [s. 24. (1) 2.]

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 any person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #7: 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 ensure that procedures that were developed for addressing incidents of lingering offensive odours were implemented.

On February 11, 2015 Inspector #138 noted room 308 bed 1 and 2 had lingering offensive odours in this resident room and the shared washroom.
On February 11, 2015 Inspector #547 noted room 408 bed 1 and 2 had lingering offensive odours in this resident room and the shared washroom.

On February 17, 2015 Inspector #547 noted that both rooms 308 and 408 and their respective washrooms in these shared resident rooms continued to have lingering offensive odours. Interview conducted with Staff #135 indicated that the lingering offensive odour comes from the resident shared bathroom between rooms #307 and #308. Maintenance is aware of the repairs required, and housekeeping wash the floors regularly up to four times a day, however the odours continue to linger. Staff #135 indicated he was aware of the odours in the shared resident bedroom #308 but thought they were coming from the washroom.

On February 18, 2015 Inspector #547 interviewed the Support Services Manager in the home regarding the home's procedures for lingering offensive odours, and they have implemented a quality improvement project plan for the home as of March 12, 2014. The Support Services Manager indicated that the third and fourth floors had the plan in place, yet the lingering offensive odours persisted in these rooms, that they were not acceptable and would require follow-up. [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 that procedures that were developed regarding incidents of lingering offensive odours are implemented and that the odours are addressed, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

On February 11, 2015 Inspector #547 observed a medication cart inside the fourth floor nursing/medication station to be unlocked and not attended by any registered nursing staff. This floor nursing/medication station has a half door to limit entrance to this space, however was found wide open during this RQI inspection. The cupboard for the medication destruction pail next to the medication cart was also noted to be unlocked, which has a sign on the door indicating that this door is to be kept locked at all times. The medication treatment cart containing prescription creams and ointments for the residents on this floor was not locked. The fourth floor nursing/medication station also had a small fridge containing prescription injectable medication and vaccines which was not locked and accessible to all who enter this nursing/medication station.

Inspector #547 interviewed RN #122 on this same date, who indicated that the medication carts are always to be kept locked while inside the nursing station, as this home does not have a separate space for their medication room. RN # 122 indicated that all staff access this space, including residents and families. Registered nursing staff are responsible to apply medicated creams and ointments, however the treatment cart has never been locked. RN #122 further indicated that the fridges have never been locked in

the home.

Inspector #138 observed on February 17, 2015 in the second floor nursing/medication station, Resident #052 wander into the nursing station on this unit via a door that was wide open and simply stand in this space for two minutes looking around the room until a staff member entered this space and re-directed him/her out. The medication treatment cart containing prescription creams, ointments and sprays for the residents on this floor was not locked or supervised by any registered nursing staff during this time.

On February 17, 2015 Inspector #547 interviewed the Director of Care who indicated that medication carts, the cupboards for the medication destruction pail, the treatment cart, and medication fridges are to be kept locked at all times. The Director of Care further indicated that the doors to the nursing/medication stations are also to be closed at all times, as indicated on a sign on the second floor door.

On February 20, 2015 Inspector #547 was in the fifth floor nursing/medication station and noted that the door to the medication destruction pail was not locked and was unattended. The sign on the front of this door indicated that this door must remain locked. Interview with RPN #144 who arrived in the nursing/medication station and tried to lock this door with her key, however it was unable to be locked and required manual locking from the door knob on the inside of the door.

The Administrator provided Inspector #547 a copy of the Medical Pharmacies - Pharmacy policy and procedure Manual for LTC Homes section 3- policy 3-4 dated 01/14 which stated that all medications are safely stored and supervised in accordance with applicable legislation.
Page 1 of 4
Procedure : A. Prescription Medications
1. Keep medication room locked at all times with the keys in possession of a designated nurse.
Page 2 of 4
c. The Refrigerator
1. Store all medication requiring refrigeration in a separate refrigerator upon receipt, not with food or laboratory specimens. This fridge must be locked in the medication room and refrigerated narcotic/controlled medications require double locking. [s. 130. 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 all areas where drugs are stored such as medication carts, medication destruction areas, fridges containing medications, and treatment carts containing prescribed creams and ointments are kept locked at all time when not in use, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy Resident Abuse #OPER-02-02-04, November 2013 version, defines resident to resident sexual abuse as non-consensual touching, behaviour or remarks of a sexual or sexually exploitative nature that is directed towards a resident by a person other than staff.

A progress note from a specific date stated that it was reported by Resident #047 that Resident #044 entered his/her room, walked straight to him/her, and grabbed a specific body part.

In an interview with Inspector #556 Resident #047 stated that following the incident he/she felt sexually abused.

In an interview RN #133 stated that when the incident happened she documented it in

the progress notes but did not verbally report it to a manager. RN #133 stated that the home has a policy to promote zero tolerance of abuse and she has received training on it annually.

In an interview the ADOC stated that every morning she reviews the report from the previous 24 hours, which includes all progress notes, and follows up with the staff on the floor as necessary. She then reports anything out of the ordinary at the daily morning management meeting.

In an interview the Administrator and the Director of Care indicated that the home did not report the incident to the MOHLTC.

The home's policy indicated that all persons in the home were to immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care, or their designate who must report the incident to the MOHLTC Director through the Critical Incident Reporting System.

In an interview on February 17, 2015 the Administrator stated to Inspectors #117 and #556 that an internal investigation had been conducted into the incident but was unable to provide documentation of the investigation.

On February 20, 2015 the Administrator requested an interview with Inspector #556 stating that she wanted to provide additional information regarding the incident. The Administrator stated that because they knew the residents involved the managers of the home did not interpret the incident as being sexual in nature and therefore they did not conduct an investigation.

The home's policy Resident Abuse #OPER-02-02-04 indicated that upon being notified of suspected or witnessed abuse the Administrator / Director of Care / Designate was to initiate an internal investigation and document pertinent details of the investigation, including actions taken during the investigation and any actions taken as a result of the outcome of the investigation, and the documentation was to be kept in a secure location. [s. 20. (1)]

2. On a specific date, Resident #048 reported to RN #122 and RPN #123 an incident of alleged abuse that had occurred with PSW #121. Resident #048 reported that PSW #121 told the resident to shut up and instructed the resident not to use the call bell. This incident was not immediately reported to either the management of the home or the

Director (MOHLTC).

The following day Resident #048 again voiced some concerns to RPN #110 regarding the care received by PSW #121 the previous evening. RPN #110 stated to the inspector that the concerns were not specific but she requested that Social Worker #112 visit the resident to obtain further information. Social Worker #112 visited Resident #048 that same day at the request of the RPN #110. The Social Worker stated to the inspector that she visited Resident #048 and the resident reported to her that PSW #121 told the resident to shut up, told the resident not to use the call bell, and pushed the resident's arm causing it to hurt. The resident also expressed that he/she was scared to use his/her call bell. Social Worker #112 immediately reported the resident's concerns to the Assistant Director of Care #111. The Assistant Director Care #111 stated to the inspector that Social Worker #112 reported the resident's concerns that day adding that this was the first that she had heard of any concerns. The Assistant Director of Care #111 further stated that she immediately proceeded to the resident's home area, where PSW #121 was working, and immediately suspended Staff #121 until an internal investigation could be conducted.

The inspector reviewed the home's policy on abuse and noted that the policy stated that all staff are to immediately report any suspected abuse to the Administrator or Director of Care (or designate) and in the case where suspected abuse causes harm to a resident, the suspected abuse must be reported to the MOHLTC Actionline.

The inspector spoke with the home's Administrator who stated that RN #122 did not immediately report the suspected abuse between Resident #048 and PSW #121 to management. A review of the home's internal investigation documents by the inspector demonstrated that RN #122 was disciplined for failure to immediately report the alleged incident of abuse between Resident #048 and PSW #121. It was also noted by the inspector that the Director (MOHLTC) was not notified immediately when RN #122 and RPN #123 became aware of the incident but was notified later the following evening after the Assistant Director of Care had been made aware of the incident. [s. 20. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to comply with section 71.(4) of the regulation in that the licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

Inspector #138 observed the breakfast meal service on February 17, 2015 on the second floor. The menu for the day was reviewed with FSW #129 and it was noted that two pureed menu items were not available, the pureed bran muffin and the pureed mangos.

Inspector also observed at this breakfast meal that residents were not offered a choice of cereals as per the menu but were given either hot or cold cereal based on routine. Residents were also not consistently offered a choice between the toast or bran muffin that was available according to the menu. Specifically, Resident #050, who has a low BMI and goal to increase weight as per the plan of care, was not offered a choice of cereal but was provided hot cereal. The resident did not eat the hot cereal and no other choice of cereal was provided. The same resident was provided toast as the second portion of breakfast but was not offered the eggs that were on the menu. It was also observed that Resident #052, who sat at the same table as Resident #050, was not offered any cereal and was not offered eggs. The inspector spoke with PSW #132 who was seated at the table to assist both residents and she stated that the residents are provided their meals by the serving staff based on the meal roster information. The inspector reviewed the meal roster for Resident #050 and Resident #052 and noted that there was no information that would direct staff not to offer a choice of cereal or eggs. [s. 71. (4)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 73. (1) 11. in that the licensee failed to ensure that there is appropriate furnishing in resident dining area on second floor.

It was observed by Inspector #138 throughout the course of the inspection that there were five residents on second floor who did not have an appropriate dining room table for the meal service. Instead of dining room tables, these residents were provided their meals on an over bed table or on a lap tray. The over bed tables were noted to be on wheels that were not locked and that the tables, by design, are only supported on one side contributing to a table surface that tilts and is unstable. The use of a lap tray limited space for the meal. Both the over bed tables and the sole use of a lap tray without a dining room table do not contribute to a home-like environment according to the preamble of the Act.

The inspector also noted in each dining room that there were several tables that had tilted surfaces. The inspector spoke with the Manager of Dietary Services and the Food Service Supervisor regarding these tables. Both acknowledge they were aware and further stated that the home is in process for replacing these tables. [s. 73. (1) 11.]

Issued on this 27th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY PATTERSON (556), LISA KLUKE (547), LYNE DUCHESNE (117), PAULA MACDONALD (138)
Inspection No. / No de l'inspection :	2015_295556_0005
Log No. / Registre no:	O-001546-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 27, 2015
Licensee / Titulaire de permis :	NEW ORCHARD LODGE LIMITED 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE LAURIER MANOR 1715 MONTREAL ROAD, GLOUCESTER, ON, K1J-6N4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PAMELA NISBET

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To NEW ORCHARD LODGE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Order / Ordre :

The licensee is required to ensure that elevator #1 is equipped to restrict resident access to the service corridor. While the licensee is addressing elevator #1, the licensee must immediately mitigate any risks relating to the accessibility of the staff kitchen.

Grounds / Motifs :

1. The licensee failed to comply with section 10.(1) of the regulation in that the licensee failed to ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

Inspector #138 was on elevator #1 and observed a staff member access a service corridor on the ground floor via the rear door of the elevator by simply pressing the "door open" button without visibly accessing any mechanism to restrict access through the rear door of the elevator. The inspector returned to the same elevator mid-morning on February 17, 2015, and was able to call the elevator to the ground floor, hit the rear "door open" button which opened the rear elevator door and then was able to access the service corridor. The inspector toured the service corridor and noted that it contained a staff kitchen/lunch room, the main kitchen, the laundry room, several washrooms, an office, a locked electrical room, and a locked service door to the outside. The inspector further toured the staff kitchen/lunch room and observed access to a water dispensing machine with a hot water feature, no call bell, and several windows at ground level that opened fully to about three feet. Staff in the staff kitchen/lunch room stated to the inspector that the room was not locked and is always open for all shifts, days, evenings, and nights.

The inspector spoke with the Support Services Manager regarding the access to the service corridor through the rear elevator door. The Support Service Manager stated that residents are not to access the service corridor thus the locking mechanism on the double doors directly beside the elevator leading to the service corridor. The Support Service Manager further stated that the locking mechanism for the rear elevator door was on by pass mode in order to allow staff to call the elevator from the service corridor. The Support Services Manager stated that it was impossible, due to the age of the elevator, to restrict access to the rear elevator door from the inside of the elevator while allowing staff to call the elevator from the service corridor.
(138)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Wendy Patterson

Service Area Office /
Bureau régional de services : Ottawa Service Area Office