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
Apr 29, 2015	2015_287548_0001	O-001494-15, O-001240-14, O-001274-14, O-002167-15	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

RUZICA SUBOTIC-HOWELL (548)

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 15,16,19,20,21 and 22, 2015

Complaint inspections conducted were Logs#:O-001494-15, O-001240-14 and O-001274-14. The inspector reviewed resident health care records, home policies, observed resident to resident interactions, resident common areas, resident rooms, observed staff to resident interactions.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Administrator, Director of Care, Associate Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Social worker, Office Manager, Resident Coordinator and Corporate Manager.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting a pressure ulcer was reassessed at least weekly by a member of the registered nursing staff.

It was reported by the hospital that upon arrival on a specified day in February, 2015, that Resident #3 presented with a pressure ulcer.

The first documentation of this pressure ulcer was on specified day in November, 2014, the progress note indicated that there was an open area at the coccyx region. The progress note went on to described depth and circumference of the wound. No wound assessment was completed on either of these dates and it is noted that there was no assessment of the wound until a specified day in December, 2014.

On specified day in December, 2014 the Enterostomal Therapist (ET) identified the stage of the wound and described the depth, granulation, circumference, exudate, red color of the skin and odor. The ET made recommendations for the care of the wound. In addition, the ET indicated that if no decrease in odor or red color of the skin by a specified day in December, 2014 that a request was to be made to the physician to order a systemic antibiotic.

On a specified day in December, 2015 upon record review it is noted in the Resident

Assessment Instrument- Minimum Data Set (RAI-MDS) that Resident #3 coccyx wound was described as a stage 3 pressure ulcer. It is noted from a specified day in December, 2014 to a specified day in January, 2015 that there is no documentation of an wound assessment of the pressure ulcer in the resident's health care record.

On a specified day in January, 2015, the Nurse Practitioner (NP) indicated the Resident's #3 pain level and that the wound was a stage X coccyx ulcer and went on to describe the depth, circumference, odor, color, and the amount of sloughing observed. The NP recommended that the current dressing treatment be changed every 2 days and prn and to continue with the same wound care as previously recommended.

On a specified day in January, 2015 the resident was examined by a Physician. In the progress notes the physician describes the wound to be an ulcer circumference and that it is deep to the bone. A swab of the wound was obtained and on specified day in January, 2015 the Culture and Sensitivity result of the wound indicated that the wound was positive for bacterium and antibiotic therapy was prescribed. It is noted that the resident was administered the prescribed medication as ordered.

On a specified day in January, 2015 on the Wound Care Record the coccyx wound is described as unstageable with drainage and odor, beefy red in color to the edges.It is noted that the registered nursing staff who assessed the wound documented that a Physician referral would be made as a result of the assessment.

On February 13, 2015 during an interview RN S#116 indicated that the home's practice is to initiate a Wound Assessment for all residents that present with altered skin integrity related to a pressure ulcer and it is expected that registered nursing staff monitor the wound on a weekly basis.

On a specified day in February, 2015 during an interview both Director of Care (DOC) and Assistant Director of Care (ADOC) confirmed that any resident presenting with any stage pressure ulcer at any time should have a weekly wound assessment completed for the monitoring of a wound.

It is noted that there are no weekly assessments completed for the altered skin integrity specific to the pressure ulcer on the coccyx. As such, the licensee failed to ensure that a resident exhibiting a pressure ulcer was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 registered nursing staff complete weekly wound assessments, if clinically indicated, to be implemented voluntarily.

WN #2: 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 any of the following has occurred or may occur immediately reports 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 risk of harm to the resident.

A Critical Incident Report (CIR) on a specified day in December,2014 was sent to the Ministry and reported two separate incidents of staff to resident alleged physical abuse. It is recorded on the CIR that an incident happened on a specified day in December, 2014

and the with the same allegations another alleged incident happened on a specified day in December, 2014.

On January 19, 2015 during an interview, the DOC informed the inspector that she became aware of the first incident on a specified day in December, 2014. The DOC indicated she began her investigation after becoming made aware of the alleged staff to resident physical abuse. The DOC further indicated that she became aware of the second incident of alleged staff to resident physical abuse of involving the same resident on a another specified day in December, 2014.During the interview the DOC indicated that she knew that there were two separate situations that were not reported right away.

On February 10, 2015 during an interview the DOC indicated that the charge registered nursing staff on each unit are to report any alleged abuse incidents to the charge registered nurses. The DOC indicated that the charge registered nurses represent the home when the administrator and DOC are not present and should have immediately reported both incidents.

Registered Nursing staff S#101 documented in the progress notes on a specified day in December, 2014 that a co-resident reported a staff to resident physical abuse incident had occurred on specified day in December, 2014. On specified day in January, 2015 during an interview #S 101 confirmed with the inspector that she informed the DOC of the alleged staff to resident physical abuse when she became aware of the incident. Later that day it is recorded in the progress note that another registered nursing staff member informed the DOC on specified day in December, 2014 of the first alleged incident.

On January 19, 2015 during an interview the administrator indicated that she became aware of both of the incidents on a specified day in December, 2014 by the DOC. The Administrator indicated that she became involved in the investigation of the alleged physical staff to resident abuse at that time.

During the interview on January 21, 2014 the Administrator confirmed that the alleged physical abuse should have been immediately reported (to the Ministry) when the home became aware of the incidents of alleged staff to resident physical abuse. [s. 24. (1)]

Issued on this 1st day of May, 2015

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

Original report signed by the inspector.