Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 30, 31, Feb 1, 2, 10, 13, 2012	2012_034117_0005	Critical Incident

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, to an attending physician, to several Registered Nurses (RN), to several Registered Practical Nurses (RPN), to several Personal Support Workers (PSW), and to several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of five identified residents; reviewed the home's policies Mechanical Lift #01-02 and # 01-03; reviewed the home's policy on Resident Abuse # RESI 02-06-01, revised September 2011; reviewed the policies Medication Reconciliation and Admission, Re-admissions and On-Hold Medcations; examined a resident room and reviewed five Critical Incident Reports.

It is noted that five Critical Incident inspections were conducted during the course this inspection: #O-002491-11, #O-002081-11, #O-002549-11, #O-002634-11 and #O-000233-12.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Falls Prevention

Medication

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Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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	Legende 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007 section 3 (1) (1) in that an identified resident was not treated with courtesy and respect by a PSW. [#O-002081-11]

On a specified day in September 2011, the resident went to the nursing station to ask the nurse to put some prescription cream on his/her fingers. The resident had a medicated cream for an infection.

Three PSWs #1, #2 and #3 were at the nursing station. The resident was advised that the nurse was busy at the end of one of the hallways.

The resident placed his/her hands on the nursing station counter. The PSW #1 suddenly slapped both of the resident's hands, hard, while they were on the nursing station counter and then had his/her hand raised to do it again but stopped when the resident yelled in pain.

The incident was reported to the home's management team by the PSW #3. The home conducted an internal investigation, notified the resident's family and local police services.

2. The licensee failed to comply with LTCHA section 3 (1) (4) in that an identified resident was not properly care for in a manner consistent with his/her needs. [#O-000233-12]

On a specified day in September 2011, the identified resident asked to have the bed pan. A PSW placed a wash basin under the resident. The resident removed the wash basin due to discomfort. While removing the wash basin, the resident spilt some urine on the bed. When the PSW returned to the room, the PSW was upset with the resident for having removed the wash basin and having spilt urine on the bed. The PSW then hit the resident's right hand and forearm several times, while scolding him/her about having removed the wash basin and soiling the bed. The resident sustained bruises to the right forearm.

The incident of staff to resident abuse was report to the unit RPN and another PSW on a specified day in September 2011, by the resident's family member and the resident himself/ herself. The RPN then reported it to both the unit RN and the home's ADOC and DOC. An internal investigation was immediately initiated, local police services notified and the Director was notified.

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 rights to be treated with courtesy and respect and residents rights to be properly cared for in a manner consistent with their needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Under O.Reg 79/10 Section 8 (1) (b) the licensee has failed to comply with the requirement "Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan , policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with." [#O-000233-12]

Under the LTCHA 2007 section 20 (1) the licensee is to have a policy to promote zero tolerance. The licensee's policy Resident Abuse # RESI-02-06-01, revised September 2011, states the following under the titles:

- Reporting an Allegation : "All employees and volunteers: Immediately report any suspected or witnessed acts of abuse to: the Administrator, Director of Care or their designate".

- Accountabilities for Compliance: "All employees - Required to report any incidents of alleged, suspected or witnessed act of abuse immediately to the Administrator, Director of Care or designate."
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The licensee failed to comply with their policy of Resident Abuse in that an identified PSW did not report an incident of staff to resident abuse that occurred on an identified day in September 2011 towards an identified resident.

On an identified day in September 2011, an identified resident asked to have the bed pan. PSW #1 placed a wash basin under the resident. The resident removed the wash basin due to discomfort. While removing the wash basin, the resident spilt some urine on the bed. When PSW #1 returned to the room, the PSW was upset with the resident for having removed the wash basin and having spilt urine on the bed. PSW #1 then hit the resident's right hand and forearm several times, while scolding him/her about having removed the wash basin and soiling the bed. The resident sustained bruises to the right forearm.

The PSW #2 was called to assist PSW #1 to clean the resident and change the bed. Later that day, the resident told PSW #2 that PSW #1 had been upset when urine had split on the bed and that PSW #1 had hit his/her arm several times. PSW #2 did not report the incident of staff to resident abuse to either the unit's registered staff, nor to the home's management team nor to the Director.

The incident of staff to resident abuse was reported to the unit RPN and PSW #3 on a specified day in September 2011, by the resident's family member and the resident himself / herself. The RPN then reported it to both the unit RN and the home's ADOC and DOC. An internal investigation was immediately initiated, local police services notified and the Director was notified.

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 in regards to ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone that is reported to the licensee and is immediately investigated, as per Abuse Policy, to be implemented voluntarily.

WN #3: 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 subsections:

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 LTCHA section 6 (7) as it relates to an identified resident who was not transferred with the aid of a mechanical lift transfer on a specified date in November 2011. [#O-002634-11]

The identified resident's plan of care specifies that the resident requires a mechanical lift for all transfer in and out of bed. Transfers are to be done by 2 PSW. One is to operate the lift and other to guide and monitor the safety of resident. Only female staff are to provide care resident care.

On an identified date in November 2011, the resident was very agitated, calling out for the nurse. The resident indicated to registered staff that he/she had been hurt by a staff member.

Registered staff assessed the resident, found no signs of injuries and reported the incident to the home's management team. An internal investigation was conducted and local police were contacted.

During the investigation, a PSW admitted to transferring the resident by himself / herself, without the aid of a mechanical lift and that he/she did not follow the resident's plan of care, resulting in resident agitation and discomfort.

Issued on this 13th day of February, 2012

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