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
Jan 2, 2014	2013_284545_0001	O-000995-13	Critical Incident System

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

ANGELE ALBERT-RITCHIE (545)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 19 and 20, 2013

Critical Incident #2665-000074-13

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, two Assistant Director of Care, Registered Nurse, several Registered Practical Nurses, several Health Care Aids (HCA) and Residents.

During the course of the inspection, the inspector(s) reviewed residents' health care records, the home's Resident Abuse - Staff to Resident Policy (Reference #: OPER-02-02-04, Version: November 2013) and observed resident activities and resident to staff interactions.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. (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 provide clear directions to staff and others who provide direct care related to Resident #1's bowel care:

Resident #1's Care Plan on a specific date in May 2013 with focus on Toilet Use indicated that staff was to "provide pericare to Resident #1 and change product".

Resident #1's Care Plan on a specific date in May 2013 with focus on Urinary Incontinence indicated to complete a Bowel & Bladder assessment on significant change in condition and observe skin daily for redness or irritation.

Resident #1's Care Plan on a specific date in August 2013 indicated that Resident #1 was identified at risk for pressure ulcers related to bladder incontinence and frequent episodes of bowel incontinence.

However Resident's #1's Care Plan did not indicate a goal or interventions related to Bowel Care and need to communicate to registered staff any changes in resident's bowel condition.

Medication administration record (MAR) for Resident #1 was reviewed for the month of October 2013 and two orders for topical medicated creams were prescribed, one ordered on a specific date in March 2012 to be applied to perianal area BID PRN and the other ordered on a specific date in April 2011 to be applied to groin BID PRN.

However Resident's #1 Care Plan did not provide direction to staff related to application of prescribed medicated creams.

MAR indicated that no prescribed creams were applied to perianal and groin areas in a specific period in October 2013.

On a specific date in October 2013 progress notes from a registered staff indicated that Resident #1's groin area was reddened.

Home investigation report from Staff S-105, Staff S-104 and Staff S-103 indicated that Resident #1 was incontinent of bowel twice on one shift on a specific date in October 2013 with paste-like stools and that Resident #1 complained of soreness when cleaned.

On December 20, 2013 during interview with the Administrator and Director of Care they stated that there were issues with the care being provided to Resident #1 and that the resident had paste-like stools and that the HCAs should have reported the pasty stool to the registered staff so that creams could have been applied for the excoriation.

As such Resident #1's bowel care changes were not communicated to registered staff, care plan was not reviewed therefore clear directions to staff was not provided in order to meet resident's care needs. [s. 6. (1) (c)]

2. The licensee failed to ensure that Resident #1's privacy was respected during care provision as specified in the plan of care:

Resident #1's Care Plan dated May 20 2013 indicated that staff should maintain resident's dignity and ensure privacy during elimination.

On December 19, 2013 Resident #2, roommate of Resident #1, was interviewed. Resident #2 stated that one shift on a specific date in October 2013 he/she witnessed care provided to Resident #1 due to privacy curtain left open while care was being provided by staff.

On October 19, 2013, the home investigation report indicated that Resident #2 was watching while change of brief to Resident #1 was done.

On October 23, 2013, the home investigation report indicated that staff admitted to not always pulling privacy curtain at night when providing care.

As such Resident #1's privacy as set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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Issued on this 3rd day of January, 2014

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

Angele Albert-Ritchie (545)