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
Mar 5, 2014	2014_198117_0006	O-000133-14	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

LYNE DUCHESNE (117), RENA BOWEN (549), SUSAN WENDT (546)

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 24, 25, 26, 27, 28, 2014 and March 3 , 4, 2014

It is noted that a Critical Incident Inspection , log # O-000958-13 was conducted during this Resident Quality Inspection (RQI).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Support Services Manager, Social Worker, Program Coordinator, Physiotherapist, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), several dietary aides, several residents, several resident family members, several resident sitters and the President of the Residents' Council.

During the course of the inspection, the inspector(s) reviewed several residents health care records; reviewed a critical incident; observed February 24 and 25, 2014, lunch time meal service; observed morning beverage collation and afternoon collation passes on February 25, 26, 2014; observed medication administration to several residents on February 26, 2014; observed resident care and services ; toured the building; observed resident common areas and resident care equipment; reviewed the home's Resident Abuse-Staff to Resident policy # OPER-02-02-04 version November 2013 and the Resident Abuse by Persons Other Than Staff policy #OPER-02-02-04 version November 2013; reviewed the home's Infection Control Manual; reviewed Night Shift Cleaning Schedule for wheelchairs, basins, bedpans and urinals; reviewed Residents' Council Minutes from February 2013 to January 2014; reviewed the home's Resident Admission Package; and reviewed registered and non-registered nursing staffing schedule.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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. 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 LTCHA, 2007, S.O. 2007, c.8, s. 15 (2) (a) in

that the home's equipment was not kept clean and sanitary.

On February 24 and 25, 2014, Inspectors #546 and #549 observed that there were several unclean resident wheelchairs, walkers, commodes and raised toilet seats on the second, fourth and fifth floors.

On February 25, 2014, Inspector #117 observed that Resident #325's wheelchair had dried debris on the seat cushion and dried liquid drip marks along the side of the seat cushion and down the side of arm rests and wheels. Back cushion was partially unzipped on both sides, exposing the inside of the cushion.

On February 27, 2014, during a conversation with the DOC and the ADOC, both confirmed to Inspector #546 that it is the responsibility of the PSWs to wipe each contact surface after every individual use. The DOC and ADOC confirmed that it is the responsibility of night shift PSWs to clean and maintain wheelchairs, broda chairs, walkers and other equipment. The ADOC provided Inspector #546 with the Night shift assigned duties for both registered staff and PSWs. Inspector #546 confirmed that the assigned duties for PSWs were to pick up wheelchairs, basins, bedpans and urinals scheduled for cleaning between 10.45pm and 12 midnight and were to clean wheelchairs, basins, bedpans and urinals between 1.30-2.30am and sign that the task has been completed.

On February 28, 2014, Inspectors #546 and #549 observed dried and caked on debris on a resident basin and a soiled and stained raised toilet seat in the resident bathroom between rooms #229 and #230. They also noted that there was dried and caked on debris on a basin in resident's room.

On February 28, 2014, it was noted on the second floor and on the fifth floor that several resident rooms did not have basins. The cleaning schedule indicated these rooms had basins and the cleaning of the basins was completed. Resident #5 informed Inspectors #546 and #549 that the wheelchair had been cleaned February 26 when the scheduled cleaning was signed off on February 27, 2014.

Resident #325's wheelchair was noted to be cleaned on February 28 after Inspector #546 had spoken to the ADOC on February 27, 2014. It was noted that there was no sign off sheet for the cleaning of Resident #325's wheelchair and no information as to when the wheelchair had last been cleaned prior to February 28, 2014.

Each floor, has a binder with the assignment schedule with the Resident Care Manual's policy (Cleaning Resident Care Equipment; document 06-02-01, last revision December 2002) including the purpose and cleaning procedure at the front of the binder, stating:
Purpose: to clean and maintain wheelchairs, Broda Chairs, walkers and other equipment.
Cleaning Procedure:
1. Wheelchairs, Broda, Geri chairs and walkers will be cleaned on a weekly basis at night by Nursing.
2. Each night, each floor will have an assigned schedule of equipment to clean.
3. A binder with the list of chairs to be cleaned each day will be placed on each unit.
4. PSWs must sign this book upon completion of the cleaning.
5. A basic maintenance check will also be done at the time of cleaning (general functioning of chair, brakes in working order, no cracks in upholstery).

Inspector #546 reviewed the binders for each floor/unit. Several of the assignment schedule sheets titled as Night Shift Cleaning Schedule Wheelchair, Basins, Bedpans, Urinals are not indicating which week the cleaning schedule is for and several assignments are left unsigned. Inspector #546 inquired as to the follow up procedures when PSW sign off signatures are missing with the ADOC who stated that every binder is reviewed daily. When missing signatures are identified, the ADOC stated that she meets with the staff and the cleaning of missed equipment is done the next night. There is no documentation to support the cleaning of missed equipment for the following night, indicating that the cleaning was completed. There is no documentation to support a follow-up action. [s. 15. (2) (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 resident care equipment, especially resident wheelchairs, raised toilet seats, commodes, basins and bed pans, are kept clean and sanitary, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA , 2007, S.O. 2007, c.8, s. 6 (1) (a) in that the plan of care did not set out the planned care for two residents.

Resident #2 is identified as having responsive behaviours. The resident presents with verbal and physical aggression especially during the provision of personal care and dressing. At the time of the inspection, it was noted that Resident #2 was wearing only nightgowns. Staff members S#116, S#130, S#131 and S#132 reported to Inspector #117 that they have been dressing the resident in nightgowns for several months as these are the resident's only adaptive clothing. Staff members report that it was recommended by the psychogeriatric outreach team and the Behavioural Support Ontario (BSO) team, several months ago, that Resident #2 wear adaptive clothing to facilitate resident care and minimize aggression. These suggested interventions are documented only in the BSO team binder. The use of adaptive clothing as a behavioural intervention is not documented in the resident's plan of care. [s. 6. (1) (a)]

2. Resident #3 is identified as having responsive behaviours. The resident presents with verbal and physical aggression especially during the provision of personal care and dressing. At the time of the inspection, it was noted that Resident #3 was wearing only nightgowns. Staff members S#116, S#130, S#131 and S#132 reported to Inspector #117 that they have been dressing Resident #3 in nightgowns for several months as this was as per Resident #3's family's request. The nightgowns are Resident #3's only adaptive clothing. Staff members S#116, S#130, S#131 and S#132 reported to Inspector #117 that it was also recommended by the psychogeriatric outreach team and the Behavioural Support Ontario (BSO) team, several months ago, that the resident wear adaptive clothing to facilitate resident care, minimize aggression and minimize the risk for potential injury as the resident tries to disrobe when wearing regular clothing. These suggested interventions are documented only in the BSO team binder. The use of adaptive clothing as a family preference and as a behavioural intervention is not documented in the resident's plan of care. [s. 6. (1) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 39 in that the licensee did not ensure that mobility devices, specifically walkers, are available at all times to residents who require them on a short-term basis.

Resident # 467 returned from hospital on an identified day in February 2014, following surgery. Review of the physiotherapy progress notes dated the day after the resident's return, indicates Resident # 467 requires a frame walker for ambulation. These same progress notes state, "We don't have any extra frame walker available. Residents POA have been contacted by writer to get frame walker for resident ASAP". Without a framed walker, Resident #467 is dependent on two staff members to assist with ambulation.

On February 27, 2014 during an interview, the Program Coordinator and Physiotherapist stated to Inspector #549 that Resident #467 does not have the use of a frame walker for ambulation. The Physiotherapist confirmed that there are no extra walkers available for resident short term needs. [s. 39.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA ,2007,S.O. 2007, c.8, s 57 (2) in that the licensee did not respond in writing within 10 days of receiving a concern or recommendation to the Residents' Council.

On February 25, 2014, the President of the Residents' Council confirmed during an interview with Inspector #549 that the Residents' Council does not receive written responses within 10 days from the Administrator when there is a concern or recommendation brought forward by the Residents' Council.

On February 26, 2014, the Administrator confirmed to Inspector #549 that a written response is not given within 10 days to the Residents' Council when concerns or recommendations are brought forward by Residents' Council. [s. 57. (2)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 67 in that the licensee has not consulted regularly with the Residents' Council at least every three months.

On February 25, 2014, the President of the Residents' Council confirmed during an interview with Inspector #549 that the Administrator/designate does not meet regularly with Resident Council or at least every three months.

On February 26, 2014, the Administrator confirmed to Inspector #549 that the Administrator/designate does not meet regularly with the Residents' Council or at least every three months. [s. 67.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 107 (3) 4, in that the licensee did not inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Resident #467 health care record indicated that on a specified day in February 2014, the resident fell, was sent to hospital and diagnosed with an injury.

The Director was notified on a specific day in February 2014, 7 days after the incident occurred.

On February 27, 2014, the administrator stated to Inspector #549 that the Critical Incident Report was started on the day of the resident's injury and transfer to hospital, but was not submitted until 7 days later and not within legislated timelines for reporting critical incidents [s. 107. (3) 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s 228 (3) in that the licensee did not ensure that improvements made through the quality improvement and utilization review system to accommodations, care services, programs, and goods provided to the residents are communicated to the Residents' Council.

Inspector #549 reviewed the Residents' Council meeting minutes from February 2013 to January 2014. There is no documentation to support that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents where communicated to the Residents' Council.

February 28, 2014, Inspector #549 confirmed with the Administrator there is no other form of documentation used to communicate with the Residents' Council. [s. 228. 3.]

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Issued on this 5th day of March, 2014

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

Lyne Duchesne RN #117 REDA BOUDEN RN #549

Susan Wendt RN #546