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
Jul 15, 2014	2014_200148_0019	O-000311-14	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

AMANDA NIXON (148)

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): July 3, 2014

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Assistant Director of Care, RAI Coordinator, Registered Nursing staff, Personal Support Workers (PSW) and family member.

During the course of the inspection, the inspector(s) reviewed the resident health care record including plan of care, hospital and admission information and assessment data.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration
Safe and Secure Home

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 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 licensee failed to comply with O.Reg 79/10, s.17 (1)(a), whereby the licensee did not ensure that the resident-staff communication system for Resident #1 was easily accessible at the residents bed location.

Resident #1 was admitted to the home on a specified date, from hospital with generalized weakness and immobility. It was determined that the resident-staff communication system at the home includes a push button call bell at the location of the resident's bed.

The health care record for Resident #1 was reviewed. Admission information provided by the Community Care Access Centre included a Client Notes Report dated two days prior to the resident's admission to the home. The Report indicates that Resident #1 was unable to use the regular hospital call bell independently.

During the inspection PSW staff #103 indicated that the resident was able to understand the use of a call bell but was not able to use the push button call bell due to a lack of mobility in the resident's hands and fingers. The Minimum Data Set (MDS) Assessment on the resident's admission indicates limitation with range of motion on both sides for hands, including wrist and fingers with full loss of voluntary movement. A family member of the resident also reported to the Inspector that Resident #1 did not have the mobility in his/her hands to use a push button call bell.

A written response from the home's Administrator to Resident #1's Power of Attorney, indicated that the issue of the accessibility of the resident's call bell was not brought to the home's attention until approximately two months after the resident's admission to the home, at which time an order was placed for a specialized call bell.

Resident #1 resided in the home for approximately two months and did not have access to the resident-staff communication system during that time. [s. 17. (1) (a)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines. O. Reg. 79/10, s. 26 (3).
2. Cognition ability. O. Reg. 79/10, s. 26 (3).
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).
4. Vision. O. Reg. 79/10, s. 26 (3).
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).
19. Safety risks. O. Reg. 79/10, s. 26 (3).
20. Nausea and vomiting. O. Reg. 79/10, s. 26 (3).
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 26(3) 2, 4, 5, 8, 10 and 12. ,

whereby the licensee did not ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of cognition ability, vision, mood, continence, risk of falls and dental and oral status, with respect to the resident.

Resident #1 was admitted to the home on a specified date, the Minimum Data Set (MDS) assessment completed on admission triggered several Resident Assessment Protocols (RAP) including the following:
-Cognitive loss
-Visual Function
-Urinary incontinence and indwelling catheter
-Mood State
-Falls
-Dental Care

A review of the RAPs indicated the need to develop a plan of care related to:
-Cognitive loss, related to decision making with the goal of maintaining cognitive status
-Visual Function related to diagnosis and need for glasses with the goal of maintaining current vision requirements
-Urinary incontinence related to the resident being incontinent of urine and bowels and need for extensive assistance with toileting with the goal of maintaining or improving the resident's incontinence
- Mood State related to the resident identified sad/worried mood with the goal of improving the resident's mood state
- Falls related to several falls in the last 90 days prior to admission with the goal of minimizing falls to 0 by the next MDS assessment
- Dental Care related to the resident having ill fitting dentures with the goal of maintaining current dental care through to the next MDS assessment

Inspector #148 spoke with staff #102, who is responsible for the home's implementation of the plan of care. Staff #102 indicated that it is the responsibility of the registered nursing staff to care plan on all items that have been triggered as a RAP.

In accordance with LTCHA 2007 s.6(1)(a)-(c), the plan of care sets out the planned care for the resident, the gaols the care is intended to achieve and clear directions to staff and other who provide direct care to the resident.

The plan of care for Resident #1 was reviewed and did not include cognition ability, vision, mood, continence, risk of falls, dental and oral status, as identified in the interdisciplinary assessment on admission. [s. 26. (3)]

Issued on this 15th day of July, 2014

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