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
Oct 9, 2013	2013_200148_0038	O-000506-13, O-000685-13	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

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 7, 2013 on site.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Environmental Supervisor, Registered nursing staff, family members and residents.

During the course of the inspection, the inspector(s) reviewed the health care records of two residents, reviewed policies related to the medication management system and reviewed census records. In addition, an identified resident was observed.

The following Inspection Protocols were used during this inspection:
Medication

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.8 (1) (b), whereby the licensee did not ensure that policies related to the dispensing of medications were complied with.

In accordance with O.Reg 79/10, s. 114 (2), the licensee shall ensure that written policies are developed for the medications system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's policy titled Leave of Absence with Medications, policy #11-15, was provided to the Inspector by the DOC. The policy instructs registered nursing staff to complete a Leave with Medication Form prior to a resident's absence from the home. The Form is to include a list of the medications being released including the directions as to when and how the medication is to be given and any special instructions.

The census record for Resident #1 demonstrates that the resident has taken several vacation and casual absences from the home in 2013.

The Registered Practical Nurse (RPN), who is regularly responsible for the resident's care on the unit, reported that the Leave with Medication Form is to be completed each time the resident is absent from the home.

Upon request, the RPN could provide the completed Leave with Medication Form for two of the absences in 2013. Forms for the subsequent absences could not be located.

An interview with the Administrator indicated that the policy instructing staff to use the Leave with Medication Form has not been followed consistently in the past. Registered nursing staff have been recently re-trained on the use of this policy.

The policy titled Leave of Absence with Medication was not complied with, in that the Leave with Medication Form was not completed for all absences of Resident #1. [s. 8. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.129 (1)(a)(ii), whereby the licensee did not ensure that drugs are stored in an area or a medication cart, that is secure and locked.

On a specified date, Registered Practical Nurse (RPN) #S102 found a bottle of antiseptic solution at Resident #2's bedside. The solution was removed at that time.

The home investigated the incident and concluded that the resident had an adverse reaction after having ingested a portion of the solution. The home further concluded that the solution was left at bedside after a registered nursing staff member provided treatment to the resident.

The licensee did not ensure that a drug was stored in a secure and locked area. [s. 129. (1) (a)]

Issued on this 9th day of October, 2013

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

Amanda Nei RO LTCH Inspector