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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 4, 2015	2015_287548_0004	O-001549-15	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 NEW ORCHARD LODGE
99 NEW ORCHARD AVENUE OTTAWA ON K2B 5E6

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

RUZICA SUBOTIC-HOWELL (548), ANANDRAJ NATARAJAN (573), LINDA HARKINS (126), MELANIE SARRAZIN (592)

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 17,18,19,20, 23,24 and 25, 2015

One Complaint inspection was conducted concurrently for Log#:O-000891-14

During the course of the inspection, the inspector(s) spoke with Residents and Family Members, Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses(RPN),Support Services Services Manager (ESM), Food Services Manager, Office Manager,Personal Support Workers (PSWs, Health Care Aide,Dietary Aide,Activity Aide, Physiotherapy Aide.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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 has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 15 (2) (a) in that the licensee did not ensure that the home's furnishings and equipment are kept clean and sanitary.

During resident observations conducted during Stage 1 of the Resident Quality Inspection (RQI), Long Term Care Homes (LTCH) Inspectors #126, #592 and #548 observed several soiled Residents' equipment. As a result, Inspector #592 further inspected the ambulation equipment for three Residents on February 23, 2015:

• Resident #2's wheelchair frame was observed to be dusty and covered with dry debris and white matter on both arm rests, wheelchair cushion, seatbelt, seat and back rest.
• Resident #9's walker was observed with white dusty residue on the wheels and base of the wheelchair. Dry beige debris was observed crushed on the wheels and wheel base. Food debris was observed on the foldable seat and on both foam hand grips of the walker.

• Resident #17's walker was observed with white matter on the black foam seat and the frame was observed to be dusty.

On February 23, 2015 during an interview with PSW S#104 indicated that the PSW's who are scheduled to work nights are responsible for the cleaning of all ambulation

equipment. PSW further indicated to inspector #592 that there is a Wheelchair Cleaning Schedule in a binder located at the nursing station for staff to follow for the specific day that equipment is to be cleaned.

On February 23, 2015 during an interview the DOC indicated to inspector #592 that the immediate cleaning of ambulating equipment is the responsibility of the PSW's. The DOC told inspector #592 that PSW's who are schedule on nights are responsible to do the regular cleaning as per the schedule. The DOC further indicated that there is a tracking sheet for the PSWs to record when cleaning of the equipment is been done. In addition, the DOC told the inspector #592 that the Program Manager is responsible for the scheduling of a vendor Company who comes in quarterly to clean the resident's ambulating equipment. The DOC was shown Resident # 2 and #9 ambulating equipment during a tour with inspector #592. The DOC told inspector #592 that the equipment for Resident #2 and Resident #9 were not cleaned and that she would take care of it.

Upon review of the Wheelchair Cleaning Schedule, it was indicated that Resident #2 wheelchair was to be cleaned each Saturday. No recording documentation was found for Saturday the 7th, 14th and 21st of February 2015.

Upon review of the Walker Cleaning Schedule, it was indicated that on alternate Monday's the North and South Corridors walkers were to be cleaned and the East corridor walkers were to be done the following Monday. No recording documentation was found for Resident #9 and #17.

During the review of the monthly calendars, the Administrator noted that the North and South corridors were not indicated on the monthly calendar for January and February due to an editing error. Therefore Resident #9 and #17 ambulating walkers were not cleaned. [s. 15. (2) (a)]

2. The Licensee failed to comply with section 15(2)(c) of the Act in that the Licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On January 20, 2015 it was observed by Inspector #573 on the 2nd floor East wing ARJO – ENCORE, sit to stand lift there was disrepair to the supportive arm rests. The arm rests are made of dense foam. The right arm rest lower section is chipped, the edges were ripped for approximately 10 inches and broken with ragged edges exposing the metal frame underneath the foam. The left arm rest lower section is chipped away

with ragged edges approximately 3 inches.

The 2nd floor North and South wing ARJO – ENCORE sit to stand lift had supportive arm rests were in disrepair. The right arm rest lower section was chipped with ragged edges for approximately 5 inches exposing metal frame underneath the foam and the left arm rest lower section has ripped foam with ragged edges for 3 inches.

In the 1st floor Spa room, Inspector #573 observed an ARJO – ENCORE sit to stand lift supportive arm rests were in disrepair. The right arm rest lower section is chipped with ragged edges for approximately 4 inches exposing the metal parts of the arm rest .The Left arm rest lower section has ripped foam.

On January 23, 2015 the home's Administrator and Support Services Manager both stated that the ARJO - ENCORE sit to stand lifts supportive arm rests were replaced in the past and the sit to stand lift arm rests get damaged when the lift gets caught in residents wash room support bars during transfers. The Administrator agreed with the inspector that the supportive arm rests are not safe for residents use and need to be replaced. [s. 15. (2) (c)]

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 the home's ambulating equipment are kept clean and sanitary, to be implemented voluntary.
2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's ARJO – ENCORE sit to stand lift supportive arm rests are in safe condition and in a good state of repair , to be implemented voluntarily, 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 has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident related to shaving facial hair.

On February 17 and 18, 2015, during stage 1, Resident Quality Inspection (RQI), Resident's # 006 and #013 were observed to have long facial hair.

Residents # 006 and #13 health care records were reviewed. Is was noted that in the plan of care there was documentation related to hygiene, grooming and bathing. No documentation found related to shaving of facial hair.

On February 23, 2015, Resident #13 was observed to have several long facial hairs on the resident's chin (1-11/2inches). Discussion with Registered Practical Nurse (RPN) S# 113 and Personal Support Worker (PSW) S# 114, they both indicated that it is very difficult to shave resident # 13 has the resident has a lot of responsive behaviors. Resident # #13 receives two baths a week during the day shift. S# 114 is full time day PSW, indicated that resident #013 usually cooperates with care, but lately they have tried offering a chocolate bar and pop but the resident continued to refuse to be shaved.

On February 24, 2015, Resident # 06 was observed having several facial hair on the upper lip and chin (1/2 inch). Discussion with Registered Nurse (RN) S#105 and PSW S#115 indicated that because resident behaviors it can be challenging to shave the facial hair off. Resident # 06 receives 2 baths a week during the evening shift. S#115 indicated that she will try and shave the facial hair of resident #06.

There is no written potential effective interventions documented in the plan of care on how to approach resident related to the shaving of facial hair. [s. 6. (1) (c)]

WN #3: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with; In accordance with R. 114(2).

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

On February 19, 2015 it was observed on first floor by inspector #592 that the refrigerator located beside the nurse's station contained one vial of Vaxigrip.

RPN #100 who was present told inspector #592 that all vaccines are expected to be kept in the vaccination refrigerator on the second floor located in the Medication room with a log temperature book. RPN further told inspector #592 that the vaccine was in the wrong refrigerator and that registered nursing staff do not keep track of the refrigerator temperature on the first floor.

Later that day, during an interview with the ADOC confirmed to inspector #592 that the vaccines are expected to be kept in the vaccination refrigerator on the second floor in the medication room and should include the recording of the temperature as per the home's policy and Public Health recommendation.

Upon a review of the Pharmacy Policy and Procedure #3-4 Medication Storage dated on 01/14. It is indicated;
C. The Refrigerator
3. The refrigerator used to store vaccines will be monitored regularly and temperatures documented as per Public Health Directives.

Later that day, during an interview the ADOC told inspector #592 that the vaccines are expected to be kept in the vaccination refrigerator with the recording of the temperature as per the home's policy and Public Health recommendation.

Therefore, the home did not comply with the medication storage policy for keeping the Vaxigrip vaccine in the refrigerator use to store vaccine and they did not monitored the temperature as per home policy. [s. 8. (1) (b)]

WN #4: 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 has not ensured that the resident-staff communication and response system is available in all areas accessible by residents on the 1st and 2nd floor sitting area located in close proximity to the nursing station.

On February 17, 2015 it was observed by Inspector #573 that there was no resident-staff communication and response system available on the 1st and 2nd floor units sitting area near the nursing station.

On February 25, 2015 during an interview all three staff members S #101, S #121 and S #122 on the 1st and 2nd floor units indicated that the area in front of the nursing station is an official resident area accessible to all residents on the units.

On February 25, 2015 during an interview the administrator and inspector #548 observed the area in front of the nursing station on the 2nd floor. The administrator confirmed that the area is accessible to all residents and this applied to the 1st floor unit. The administrator indicated that he was not aware of the need for a resident-staff communication and response system due to the proximity of the area to the nursing station. The administrator confirmed there was no resident-staff communication and response system at the nursing station. The administrator indicated that the installation of a resident-staff communication and response system in these areas could be quickly remedied. The administrator informed the inspector #548 that he had placed a call to their outside vendor to install the resident-staff communication and response system for the 1st and 2nd floor units sitting areas. [s. 17. (1) (e)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.37 (1)(a), whereby the licensee did not ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labeled within 48 hours of admission and of acquiring, in the case of new items.

The following were observed by Inspector #573 over the course of this inspection:

On 1st floor Dementia unit:

Room 104 shared bathroom, it was noted that there was 1 blue tooth brush and 2 toothpaste unlabeled in a cup on the sink counter. Inspector observed 1 petroleum jelly (used) and 1 Infrazinc cream (used) unlabeled on the Resident #19 bedside table.

Room 115 shared bathroom, Inspector observed 2 used denture cups unlabeled on the side of the sink counter. It was noted that there was 1 used denture cup on the Resident #18 side table with no name or label.

Room 122 shared resident's room, 1 petroleum jelly (used) and 1 topical skin cream (used) unlabeled on the Resident #08 side table.

Room 127 shared resident's room, it was noted that there was 1 used denture cup, 1 petroleum jelly, 1 Infrazinc cream and 1 hair brush (used) unlabeled in the Resident #20 side table.

Room 130 shared resident's room, 1 hair brush and 1 petroleum jelly (used) with no label on the Resident #21 side table.

On February 17, 2015 Inspector #573 observed the following resident personal items (used) with no name in 2 unlabeled baskets in the 1st floor Spa room.
1 hair brush
1 Nivea cream
1 barrier cream
1 Vita rub cream
1 wound cleanse bottle

On 2rd floor: -Room 211 within a shared resident's room, it was noted that there was a

used denture cup unlabeled on the Resident #16 side table and Inspector observed 2 finger nail clippers unlabeled on the Resident #22 side table.

On February 19, 2015 in the nursing station of the Dementia Unit, Inspector # 573 observed 15 pair of eye glasses in a red basket unlabeled.Registered Nursing (RN) S #116 indicated that the eye glasses belonged to residents who had passed away and resident who might have discharged from the Home in the past. The RN S #116 agreed with the inspector that none of the glasses were labeled.

On February 20, 2015 Inspector #573 interviewed the Assistant Director of Care (ADOC) who stated that the home has a policy and procedure for labeling resident personal items. The ADOC further indicated that the Nursing staff would label the glasses with stickers at time of admission.The ADOC indicated that the Home's expectation is that all the residents' personal care items are to be labeled by the nursing staff members at the time of admission or as needed. [s. 37. (1) (a)]

WN #6: 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 has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On February 18, 2015 it was observed in the Spa room located on the first floor, by inspector # 573, a jar of prescribed Clotrimaderm cream 1% in a blue tray in the beige cupboard located beside the tub.

On February 18 and 19, 2015 it was observed on second floor by inspector #573 and #592 prescribed drugs in several resident rooms.

It was observed in:
Room 211-1 a jar of Clotrimaderm cream 1 % and one jar of Vitarub ointment at the Resident's #01 bedside table.
Room 211-3 a jar of Clotrimaderm cream 1% and one tube of Metrogel 1% at the Resident's #16 bedside table.

On February 19, 2015 it was observed on first floor by inspector #592 that the refrigerator located beside the nurse's station was not locked. The refrigerator was containing the following medications:
3 vials of Lantus
One box of Calcitonine
One vial of Vaxigrip

During an interview with RPN S #100 , she told inspector #592 that the refrigerator lock pad was missing and that sometimes the lock pad was used and sometimes not. During the time of the interview, RPN S #100 was not able to locate the lock pad to lock the refrigerator.

During an interview the ADOC indicated to inspector #592 that on the first floor unit, the population is mostly resident's diagnosed with dementia and there are Resident's with wandering behaviours.

Later that day, during an interview with the Administrator, he told inspector #592 that the refrigerator lock was broken, therefore the staff members were unable to lock the refrigerator. The administrator showed Inspector #592 that the lock was repaired and that the refrigerator was now locked. The Administrator told inspector #592 that the refrigerator should be kept locked at all times. [s. 129. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the Prescriber in consultation with the resident. 131(5)

On February 18 and 19, 2015 it was observed on second floor by inspector #573 and #592 prescribed drugs in a resident room.

It was observed in:
Room 211-3 a jar of Clotrimaderm cream 1% and one tube of Metrogel 1% at the Resident's #16 bedside table.

on February 19,2015 during an interview the Resident #16, indicated to inspector #592 that Clotrimaderm cream and the Metrogel is used on a daily basis. The Resident further indicated to Inspector #592 that the resident likes to have the cream nearby in order to use.

During an interview later that day RN staff# 101 told inspector #592, that Resident #16 does not have any self-administration rights. RN indicated to inspector #592 that if it is not recorded in the Physician orders to leave medication at bedside for self-administration, residents are not allowed to self-administer.

Upon a review of Resident #16 Medication Review dated on February 3, 2015 it is indicated that Clotrimaderm cream 1% is to be applied to irritated area. No approval from the Prescriber was found.

In addition, Metrogel 1% is indicated to be apply to rash on face at bedtime. No approval from the Prescriber was found to leave medication at bedside for self-administration.

On February 20, 2015 during an interview the ADOC told inspector #592 that she was not aware that Resident # 16 was self- administering prescribed cream and that it should have been approved by the Prescriber. She further added that the home has no processes for medication self-administration. [s. 131. (5)]

Issued on this 4th day of March, 2015

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

Original report signed by the inspector.