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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2016	2016_287548_0004	002429-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

LONGFIELDS MANOR
330 BEATRICE DRIVE NEPEAN ON K2J 5A5

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

RUZICA SUBOTIC-HOWELL (548), GILLIAN CHAMBERLIN (593), KATHLEEN SMID (161)

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 2, 3, 4,5, 9,10,11 and 12, 2016.

Concurrently Log's#: 000767-15- related to a an alleged verbal abuse from a staff member to a resident, 030035-15 - related to improper care resulting in risk of harm to a resident and 001437-16 - related to a complaint of alleged medication abuse, were completed.

During the course of the inspection, the inspector(s) toured resident care areas, reviewed residents' health care records, observed infection control practices, reviewed menus, critical incident reports & investigation documentation,complaint report, reviewed resident personal equipment cleaning schedules, observed residents meal service and nourishments, observed medication administration, reviewed maintenance program and records and home policies.

During the course of the inspection, the inspector(s) spoke with the Residents, Family members, Administrator, Director of Care (DOC), Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSWs), Environmental Services Supervisor, Housekeeper, Registered Dietitian, Dietary aides, Nutrition Care Manager, Resident's Council Chair and Family Council President.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
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
Safe and Secure Home
Skin and Wound Care
Snack Observation

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

- **5 WN(s)**
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On a specified day in October, 2015 the home submitted a critical incident report describing improper /incompetent treatment of a resident #044.

Inspector #548 reviewed the home's investigative notes and the resident's #044 health care record.

On a specified day in October, 2015 a co-resident reported to the Administrator of witnessing one personal support worker transferring resident #044 improperly by mechanical lift.

Review of the health care record for resident #044 indicated the resident was dependent with the use of a mechanical lift for mobility needs.

The home has a specific form titled: Assessment Form for Lift and Transfers. The form dated for a specified day in August, 2015 for resident #044 and the resident's care plan specifies that the resident requires two persons to assist with the mechanical lift for mobilization.

On February 12, 2106 during an interview RN#100 indicated the resident requires a mechanical lift for all transfers and for safety, operating the mechanical lift for transfers requires two persons at all times.

The home's policy titled: Safety on Ambulating Lifting and Transferring Program, #HS16-P-10, revision date: August 2015, indicated that there are to be two staff members present at all times while the mechanical device is in operation.

Review of the home's investigative notes and during an interview the Administrator confirmed that the resident #044 was transferred from the bed by one personal support worker operating the mechanical lift. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care, outcomes of the care and the effectiveness of the plan of care are documented.

A review of resident #009's electronic care records, found that in a three week period of time in November, 2015 to December , 2015, the resident refused to be bathed three times. There was no documentation relating to the action taken as a result of this care refusal.

On February 8, 2016 during an interview with Inspector #593, PSW #122 reported that resident #009 sometimes refuses to be bathed. The PSW added that the resident would usually refuse if he/she was not feeling well and if this happened, they would provide a sponge bath instead. The PSW further reported that if the resident refused to be bathed, they may offer he/she a shower the next day.

On February 8, 2016 during an interview with Inspector #593, PSW #123 reported that resident #009 prefers to have a shower and that there are scheduled bathing days. This was confirmed through review of the posted bath schedule. PSW #123 further reported that resident #009 sometimes refuses to be bathed.

A review of resident #009's current care plan found that the resident requires physical assistance for bathing. The resident's shower days were documented in the care plan for two specified days during the week. There was no documentation related to the resident's refusal of bathing or the actions taken if the resident refused to be bathed.

On February 12, 2016 during an interview with inspector #593 the Administrator reported that if a resident was refusing to be bathed, the task should be reattempted later and documented or at least the resident should be provided with a bed bath with this also being documented. [s. 6. (9)]

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 the plan of care set out in the plan is provided to resident #044 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included alternative beverage choices at snacks for residents requiring a texture modified diet.

During the morning nourishment pass on February 8, 2016, on a specific home area, inspector #593 observed the cart with a selection of fluids being offered for residents. Included in these fluids, was one carton of nectar thickened cranberry juice. There was no other beverage choice available and being offered to residents requiring thickened fluids. A thickened cranberry juice was observed to be given to resident #045, however no beverage choice was given to the resident.

On February 8, 2016 during an interview with Inspector #593, PSW #118 reported that they have a selection of pre-thickened fluids available in the home including apple juice. They added that they have three residents who require thickened fluids in this area and one family member prefers the resident to have cranberry juice which is why they are offering thickened cranberry juice to these residents.

During the afternoon nourishment pass on February 8, 2016, in a specific home area, inspector #593 observed the cart with a selection of fluids being offered to residents. Included in these fluids, was one carton of nectar thickened cranberry juice. There was no other beverage choices available and being offered to residents requiring thickened fluids. A thickened cranberry juice was observed to be given to resident #045, however no beverage choice was given to this resident.

On February 8, 2016 during an interview with inspector #593, PSW #122 reported that they have a selection of pre-thickened fluids available in the home including cranberry juice, apple juice, water and milk. They added that they also use a thickener to thicken any other beverages that the resident may want.

During the morning nourishment pass on February 11, 2016, in a specific home area,

inspector #593 observed the cart with a selection of fluids being offered for the residents. Included, was one carton of nectar thickened apple juice. There were no other beverage choices available and being offered to residents requiring thickened fluids.

On February 11, 2016 during an interview with inspector #593, PSW #123 reported that they have a selection of pre-thickened fluids available in the home including cranberry juice, apple juice and orange juice. They added that they usually would have a selection of thickened fluids available however they find that the residents prefer the thickened apple juice.

On February 11, 2016 during an interview with inspector #593 the Nutrition Care Manager (NCM) reported that it is the home's expectation that there are three fluid choices, including thickened, available for all residents during between meal nourishments.

A review of the home's policy: Between Meal Nourishments, revised December 2014, found that residents quality of life will be enhanced and nutrient requirements met through the provision of between meal nourishments. The nourishment/snack cycle and delivery times will be developed according to provincial regulations. [s. 71. (1) (d)]

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 ensure all residents are offered and provided a selection of fluids with all meals and snacks, to be implemented voluntarily.

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 a required policy is complied with.

A review of the home's policy LTC-G-50: Nutrition Care Referral, revised date October 2014, found that residents with changes in health affecting nutritional status will be identified through a referral process to the Registered Dietitian (RD). An electronic referral in Point Click Care will be made to the RD with any significant change in the resident's health affecting nutritional status.

A review of the home's policy LTC-G-60: Height Measurement and Weight Management, revised June 2014, found that a nutrition referral to the RD will be completed and the information documented in the interdisciplinary progress notes for the following weight variances: Weight loss or gain of greater than or equal to 5% of total body weight over one month; Weight loss or gain of greater than or equal to 7.5% of total body weight over three months. The RD is responsible to review the monthly weight report at the end of each month to ensure all significant weight changes have been addressed.

A review of resident #023's progress notes found five entries documented for a specified period of time in January, 2016, indicating the resident's refusal of meals and reporting that the resident was not hungry.

A review of resident #023's electronic health care record in February, 2016, found 13 meal periods that were refused by the resident over the past 30 days including two periods of three consecutive days where meals were refused.

A review of resident #023's current care plan found that the resident was a high nutritional risk due to low BMI and variable intake at meals and that referral to the RD

was required if less than 50% of the meal was not consumed for three consecutive days.

On February 11, 2016 during an interview with Inspector #593 the resident #023 reported that often at meal times he/she is not hungry but then will want a snack later. The resident added that often the size of the meal provided is overwhelming and would prefer to have smaller meals and snacks more frequently throughout the day. Resident #023 further reported that he/she is often hungry at night and this affects his/her sleep.

On February 11, 2016 during an interview with Inspector #593, PSW #124 reported that it was very tiring for resident #023 to attend the dining room for meals, especially at breakfast. The PSW further reported that when resident #023 does not attend the meals, they often request a snack at a later time.

A review of resident #030's monthly weights documented on a specified day in February, 2016, found a weight loss of 7.5% or 6.5kg over a two month period.

A review of resident #023's monthly weights documented on a specified day in January, 2016, a weight loss of 5.1% or 4.4kg since the previous month.

A review of the resident's last nutritional assessment completed found that the resident was assessed as high nutrition/hydration risk.

On February 9, 2016 during an interview with inspector #593 the resident #030 reported that he/she had a reduced appetite. The resident added that recently he/she was finding it very tiring to eat meals which was affecting his/her appetite.

A review of the referrals to the RD for residents #023 and #030 found that neither resident had been referred to the RD for weight loss or reduced intake.

On February 10, 2016 during an interview with Inspector #593 the home's RD reported that they complete assessments for residents based on referrals from nursing staff. The RD added that nursing staff are required to refer for is a decline in food and / or fluid intake. The RD reported that if there was a 2kg weight loss or gain, the staff are prompted to reweigh, if the reweigh confirms the weight variance, then the staff should be referring the resident to the RD.

The RD confirmed that they had not received a referral for weight loss for resident #030. The RD further reported that they would expect to receive a referral for this significant

weight loss.

The RD confirmed that they had not received a referral for reduced intake for resident #023. The RD further reported that if a resident had a poor intake for three consecutive days, then they should be referred however if a resident was refusing meals or the residents intake was on and off, they should also be sending a referral to the RD. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a process to ensure that food service workers and other staff assisting residents are aware of the resident's diets, special needs and preferences.

A review of the diet roster revised July 31, 2015, located at the nourishment carts on a specific home area, found that resident #045 who was admitted in October, 2015, was not documented on this list. A review of the dietary binder located in a specified home area's dining room found that resident #045 was documented in the binder however it was documented that he/she required regular fluids, not nectar thickened fluids as per the care plan.

A review of the diet roster revised July 31, 2015, located at the nourishment cart in a specified home area, found that resident #046 was not documented as requiring nectar thick fluids as per the care plan. A review of the dietary binder located in specified home area dining room found that resident #046 was documented in the binder however it was documented that the resident required regular fluids, not nectar thickened fluids as per the care plan.

On February 10, 2016 during an interview with inspector #593, Dietary Aide #120 reported that they were new to the specified home area and they referred to the dietary binder for resident dietary requirements as they were not yet familiar with residents in this area.

On February 10, 2016 during an interview with inspector #593, during the afternoon nourishment pass on a specific home area, PSW #121 reported that they would refer to the diet roster attached to the cart for resident dietary requirements. They added that if they were working in another home area, which they sometimes do, they would rely on this as they do not know the dietary requirements of the residents in other home areas.

On February 11, 2016 during an interview with inspector #593 the Nutrition Care Manager (NCM) reported that they were aware that the diet rosters needed updating. They further reported that the usual process for amendments is that they request one of the dietary aides to temporarily update the forms then they will make the amendments electronically and reprint the documents. They added that usually the sheets are printed off at the start of every month to reflect any changes. [s. 73. (1) 5.]

WN #5: 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 ensure that drugs are stored in an area or medication cart that is secure and locked.

On February 2, 2105 on specific home area, inspector #548 observed the medication cart to be in front of the dining room, unlocked and unattended. Approximately four to five feet from the cart inspector #548 observed a resident in a wheelchair, a housekeeping staff member cleaning the floor of a dining room and, an family member walk in front of the cart. The cart remained unattended and unlocked for approximately 4 to 5 minutes.

The inspector #548 observed a registered staff member approach the cart from the hallway. The RPN #117 was observed to prepare medications at the cart and administer those medications to a nearby resident. Once completed, it was observed the RPN#117 walk down the hallway and enter a resident's room. It was observed by inspector #548 that the medication cart was out of her line of sight. The cart remained unlocked and unattended for an additional four minutes.

The homes' policy titled: Medication Administration, LRF-F-20, Revision date: January 2016 specifies that the medication cart will be lock when unattended or out of sight.

On February 11, 2016 during an interview the Director of Care indicated that all drugs in the home are to be safe and secure at all times and the medication cart to be locked when not in use. [s. 129. (1) (a)]

Issued on this 19th day of February, 2016

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

Original report signed by the inspector.