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
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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
Feb 21, 2014	2014_225126_0006	O-000112-4	Complaint

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

LINDA HARKINS (126)

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): February 20, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care, one Personal Support Worker and the resident

During the course of the inspection, the inspector(s) reviewed the resident health care records and observed care and services provided to residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Personal Support Services

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 36 in that safe transferring technique was not used to assist resident #1.

On a specific day in January 2014, PSW S #100 attempted to weigh resident #1. PSW S #100 asked resident #1 to stand and hold on the handrail in the hall near his/her room. Resident #1 lost his/her balance and began to fall to the floor. PSW S #100 proceeded to ease the resident to the floor. After the incident resident #1 was complaining of pain. Resident #1 was sent to hospital that evening and was diagnosed with a fracture and required surgery.

Resident #1's care plan was reviewed. It was noted that Resident #1 requires mechanical lift and sit to stand lift for transfer to be done by two staff. On a specific day in January 2014,PSW S#100 use an unsafe transferring technique on her/his own when all transfers for resident #1 are to be done with 2 staff. [s. 36.]

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 staff use safe transferring and positioning devices and techniques when assisting resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Regs 79/10 s.107. (3) 4 in that the licensee did not informed the Director no later that one business day after the occurrence of the incident.

On specific day in January 2014,resident #1 fell and sustained a fracture which required surgery. Resident #1 returned to the home from the hospital several days later. As February 20, 2014, the licensee had not informed the Director of this incident. The incident was reported to the Director via an anonymous complaint received via the info line on a specific day in January 2014. [s. 107. (3) 4.]

Issued on this 21st day of February, 2014

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