Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 27, Aug 1, 8, 2012	2012_091112_0048	Complaint

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7

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

LONGWORTH LONG TERM CARE FACILITY
590 Longworth Road, LONDON, ON, N6K-4X9

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

CAROLE ALEXANDER (112)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, 1 Registered Practical Nurse and 4 Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed the following: 4 resident clinical records for personal care provisions, the home's staffing pattern, resident falls data and resident observations were made.

The following Inspection Protocols were used during this inspection:

Sufficient Staffing

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 31. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

The staffing plan for the home has not been evaluated. The following information for the "Lilly Unit" was reviewed: written feedback from staff relaying concerns about "not having enough time to toilet" and challenges "coping with behaviours" Falls data shows the unit to have higher incidence of falls than every other home area for each month from January 2012 - July 2012
There is no evaluation of the staffing plan available.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

The Licensee did not ensure that all residents residing on the Lilly unit received individualized personal care, including hygiene care and grooming on a daily basis.
1) 2 residents were not assisted with toileting needs from on July 27, 2012 from 0800 to 1330 hours.
2) 4 residents were not bathed twice weekly for each month of June and July 2012
The inspector observed the following: 1 resident to be soiled with stool in his room, half naked and a trail of fecal matter from the bathroom to his bed where he sat. RPN stated that she had given him a laxative, resident was not assisted until the inspector raised his need for assistance. 1 resident had climbed over the bed rails and was calling for help, help was provided once the inspector requested assistance.
3) The home's falls were reviewed and the Lilly Unit consistently had more resident falls each month from January to July 2012 inclusive than any every other home area
4) 4 PSW staff information consistent in relaying that personal care needs such as dental/mouth care, toileting gets missed as time does not allow.

Issued on this 8th day of August, 2012

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