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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 17, 2015	2015_200148_0021	O-002421-15	Critical Incident System

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 16, 2015.

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, Director of Care, Registered Practical Nurse, Personal Support Workers, resident and family members.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **1 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. 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).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care was provided to Resident #1, as specified in the plan.

Resident #1 is prescribed a therapeutic diet. Each administration of the diet takes approximately 4 to 4.5 hours to complete. On a specified date, it was reported that the diet was started at 7:00pm, indicating that the administration would be completed by approximately 11-11:30pm.

On the night shift of the same date, Resident #1 was observed at midnight by RPN #S100 . The resident, who was in bed, was found with the administration of the diet completed. The resident was lying down with the head of bed in a flat position. The resident was assessed by the RPN to have his/her mouth filled with secretions, difficulty breathing with grey skin color and purple finger tips. The RPN, with the assistance of RN #S105, provided an assessment and immediate suctioning. The resident was sent out to hospital and returned with a diagnosis of aspiration pneumonia.

The plan of care for Resident #1, in place at the time of the above described incident, indicates that the head of bed is to be raised at a minimum of 45 degrees during the administration of the diet and for one hour after the administration of the diet. On the date specified, within the first hour after the administration of the diet, the resident was found to have the head of bed flat and not in a raised position. It is noted by the Inspector, that staff working the evening and night of the specified date, were unable to confirm how long the resident was in a recumbent position.

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

Issued on this 17th day of July, 2015

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

Original report signed by the inspector.