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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
May 10, 2016	2016_286547_0011	010620-16	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

LISA KLUKE (547)

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): April 21, 22, 25, 27, 2016

This Complaint Inspection log # 010620-16 is related to a concern of a resident's responsive behaviours and how the home was managing these behaviours for resident safety.

During the course of the inspection, the inspector(s) spoke with residents, a family member, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), a dietary aide, the Resident and Volunteer Services Coordinator, the Director of Care (DOC) and the Executive Director (ED)

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies that have been developed for resident #003 were implemented to respond to the resident's responsive behaviours.

This inspection was conducted as the result of info line complaint # IL-44079-OT related to log# 010620-16 regarding a concern for residents responsive behaviours of wandering around the home.

Resident #003 was admitted to the home on a specified date in October 2012 with several diagnoses including unspecified dementia.

Resident #003's health care records were reviewed and noted that resident #003's care plan identified the resident as exhibiting responsive behaviours to include anger, verbal abuse, socially inappropriate behaviour, wandering, hoarding items such as cutlery due to cognitive impairment. This care plan focus has an intervention to please remove empty glass containers from room that could be dangerous for resident on a regular basis and other objects that could be used inappropriately.

Inspector #547 observed resident #003 walking the hallways of two units in the home being unit A and unit B. Resident #003 from unit A was noted to be seated regularly outside of resident #001's room on unit B.

RPN #100 indicated to Inspector #547 that resident #003 was known to pick up cutlery and cups in the dining room on unit A and they have now implemented an intervention of not placing the cutlery on the tables in the dining room ahead of meals to prevent the

cutlery from being used inappropriately. RPN #100 further indicated that resident #003 also gets angry easily in the dining room if there is a lot of noise, and requires redirection.

PSW #101 indicated to Inspector #547 that resident #003 always walks the hallways on both units and is known to pick up items along the way. PSW #101 indicated that the staff can close the doorway for unit A, however the resident is aware of how to open this door to go to unit B. PSW #101 indicated that dietary staff no longer place cutlery on the tables before the meals in unit A due to resident #003's need to pick these items up and hoard them.

Dietary aide #102 indicated to Inspector #547 that they do not place the cutlery on the tables before the meals on unit A as resident #003 likes to pick them up and move them to other areas. Dietary aide #102 indicated that they do set the tables on unit B with the cutlery on the tables, as they eat earlier than unit A. Dietary aide #102 further indicated that this intervention was only applied to unit A's dining room where resident #003 resided.

Resident #001 indicated to Inspector #547 that resident #003 has been in the dining room on unit B as early as 0700 hours, and is taking the cutlery at that time or before lunches usually. Resident #001 indicated that this is scary as he/she is aware that this resident is impaired. Resident #001 indicated that he/she has tried to take the cutlery from resident #003 as he/she does not seem to understand speech, but then growled at resident #001. Resident #001 indicated that she has informed staff on unit B of this behaviour and that staff have indicated that resident #003 is harmless and to leave him/her alone as the resident will drop the cutlery along the way. Resident #001 believes this to be a safety concern and resident #003 should not be left alone when he/she has cutlery in hands.

RN #103 indicated that resident #003 often wanders to unit B and is known to pick up cutlery and other items along the way. RN #103 indicated that there is no way to keep resident #003 on his/her own unit, as the doors between the units do not lock. RN #103 indicated that resident #003 does not like items removed from hands as the resident will then start to yell and scream, and staff usually know to leave him/her go as the resident will place them down somewhere when distracted with another item. If staff on unit B have too much trouble with resident #003, they call unit A to ask staff to come a get the resident and redirect him/her to the resident's unit.

Inspector #547 interviewed the home's Executive Director (ED) who indicated that she was not aware of the issue of resident #003 carrying cutlery around another home unit while wandering in resident areas. The ED indicated that they do review responsive behaviours and implement interventions in the home areas for residents, but they did not consider the other units when residents are wandering with regards to applying these interventions there as well. The ED indicated that the home would review all areas this resident wanders, to ensure that all the necessary interventions are implemented to manage resident #003's responsive behaviours. [s. 53. (4) (b)]

Issued on this 18th day of May, 2016

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

Original report signed by the inspector.