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 soins 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
Nov 1, 2016	2016_380593_0029	034777-15, 008382-16, 008470-16, 012573-16, 030589-16	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

GILLIAN CHAMBERLIN (593)

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): October 18 - 20, 2016.

Five intakes were inspected during the inspection. Five reported critical incidents including logs #034777-15, #008382-16, #008470-16, #012573-16 and #030589-16 related to a missing resident, staff to resident abuse, resident to resident abuse and falls related to a change in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Dietary Staff, Personal Support Workers (PSW) and residents.

The inspector observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, reviewed resident health care records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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. 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 as per O.Reg 79/10 s. 8 (1) (b), that any required plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

As per O.Reg 79/10 s. 48 (1), every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury, and 4. A pain management program to identify pain in residents and manage pain.

A review of the home's policy titled "Pain Assessment and Symptom Management", LTC-E-80, last reviewed August 2012, found that if pain has been identified, a pain monitoring tool will be initiated for 72 hours.

A review of the home's policy titled "Fall Intervention Risk Management Program", LTC-E-60, last reviewed March 2014, found that for all falls, a complete clinical assessment will be completed and documented every shift for a minimum of 72 hours and if a fall is not witnessed or the resident has hit their head, a neurological assessment will be initiated and the resident will be monitored for 72 hours. For documentation and monitoring, neurological monitoring documentation (72hr) when applicable as per head injury routine.

A review of the home's policy titled "Head Injury Routine", LTC-E-70, last reviewed August 2012, found that a Head Injury Routine (HIR) will be initiated for all resident falls that are not witnessed, and for witnessed resident falls that include the possibility of a head injury. The Nurse will complete the Neurological Flow Sheet LTC-E-70-05.

Resident #005 sustained an unwitnessed fall on a particular date, at approximately 0400 hours.

• Two days post fall at 0846 hours, the resident complained of pain and was administered a PRN (as required) for pain relief.

• A progress note on the same day at 2121 hours indicated that the resident was complaining of pain in a particular area and it was documented that this area was quite swollen with slight redness. No PRN was administered.

• The following day at 0119 hours, the resident complained of pain "Oh, I'm in so much pain" and was administered a PRN for pain relief.

• Several hours later at 0404 hours, the progress notes indicated that the resident was whimpering in pain. It was documented that a particular area was very swollen. No PRN for pain relief was administered.

• A progress note later that morning at 1136 hours indicated that the particular area of the residents body remained swollen and the resident was groaning in pain. A PRN for pain relief was administered at 1210 hours related to the pain.

• A progress note that afternoon at 1411 hours indicated that the resident was sent to the hospital at 1345 hours for further assessment related to swelling and pain.

• A progress note later that evening at 2151 hours indicated that the resident returned to the home at 2025 hours. The resident returned with a diagnosis of an injury to a particular part of their body. A PRN for pain relief was administered.

• A progress note the following day at 1341 hours indicated that a 72 hour pain monitoring sheet and an e-TAR would be initiated.

The resident was first complaining of pain related to an injury two days post fall at 0846 hours and a PRN for pain relief was administered as a result. It was further documented that this pain continued and required further PRN medication to be administered until the resident was admitted to hospital the following afternoon at 1345 hours. A review of resident #005's health care record found that a pain monitoring sheet was not initiated until the day after they returned from hospital at 1200 hours more than 48 hours after the resident first complained of pain.

A review of the electronic physicians orders for resident #005 found a PRN order for a pain relief medication four times daily as needed. As per the eMAR, resident #005 was administered four doses of the pain relief medication from the time they started complaining about the pain, to the time they were sent to hospital. No PRN was administered in the month prior to the fall.

A review of resident #005's health care record found a neurological flowsheet initiated the time of the fall at 0400 hours. It was indicated on the flowsheet that an assessment of

the resident including vital signs was to be completed every 30 minutes for the first two hours. The 0500 hours and 0530 hours assessments required within the first two hours post fall, were not completed.

A review of resident #005's health care record found no clinical assessment in the 72 hour period following the fall for night shift the day after the fall and all three shifts (day, evening and night) two days after the fall.

During an interview with Inspector #593, October 27, 2016, RPN #105 reported that if a resident has an unwitnessed fall or they suspect a head injury, the registered nursing staff will start a head injury routine which involves three day monitoring of the resident including vital signs. RPN #105 added that even if the resident was asleep, the vital signs had to be taken as it was a suspected head injury and it was important to monitor the vital signs. In addition, the RPN reported that a falls follow up progress note is required to be completed for each shift for three days after the fall is completed, this is also done by a registered nursing staff. RPN #105 reported that three day pain monitoring would be implemented for any new pain or worsening of existing pain, as well as if they were using more PRN medication than usual for a resident.

During an interview with Inspector #593, October 27, 2016, the Administrator reported that it was the expectation of the home that the head injury routine was completed post unwitnessed falls or where a head injury was suspected. Furthermore, once the resident started complaining of pain, a pain assessment should have been started. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 1st day of November, 2016

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

Original report signed by the inspector.