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
Feb 16, 2017	2017_627138_0006	031540-16, 035410-16, 003295-17	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

PAULA MACDONALD (138)

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): February 10, 13, 14, 15, and 16, 2017.

The following intakes were completed in this Critical Inspection:
Log #031540-16, CIS #2845-0000023-16 was related to a resident injury with a significant change in condition,
Log #035410-16, CIS #2845-0000025-16 was related to a resident injury with a significant change in condition and,
Log #003295-17, CIS #2845-0000002-17 was related to falls.

Complaint Inspection related to Log 034626-16 was conducted concurrently.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, a physician, the substitute decision maker (SDM) for a resident, personal support workers (PSW), registered practical nurses (RPN), and registered nurses.

The inspector reviewed staffing schedules, 24 hour report notes, internal investigation documents, and resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

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 :

1. The licensee failed to comply with section 6.(7) of the Act in that the licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Inspector #138 reviewed the home's internal documents into the investigation of the cause of an injury to resident #001. While reading the documents, including interview notes, it was noted by the Inspector that the resident appeared to be reposition in bed by one staff, PSW #103, during the night shift. The Inspector reviewed the resident's plan of care and noted that the plan of care directs staff to provide repositioning while in bed with a slip sheet and 2 staff members. The Inspector spoke with PSW #104 and RPN #105 separately about the requirement for repositioning of resident #001 while in bed. Both staff stated that the resident is always to be repositioned with two staff members as the resident has one sided paralysis and can also exhibit responsive behaviors towards staff.

The Inspector visited the home during a night shift on February 16, 2017, and spoke with PSW #103 regarding the repositioning of resident #001. PSW #103 confirmed to the Inspector that she repositions the resident by herself with a slip sheet. PSW #103 acknowledged to the Inspector that the resident does exhibit responsive behaviors at times when being repositioned.

The Inspector was able to determine that resident #001 was not repositioned at night according to the resident's plan of care.

Log # 031540-16 [s. 6. (7)]

2. Resident #004 suffered a fall in February 2017, and an injury. The Inspector reviewed the resident's plan of care and noted that the plan of care outlined the use of protective equipment as a falls management intervention for the resident. The Inspector spoke with RPN #101 as she had completed the post falls assessment on the resident. The RPN told the Inspector that the resident was not wearing the protective equipment at the time of the fall. The Inspector further spoke with PSW #102 and the resident's SDM. Both stated that the resident was to wear the protective equipment at all times to prevent injury related to falls. The resident's SDM further stated that s/he had spent time with the resident earlier the day of the fall and noticed that the resident was not wearing the protective equipment. The SDM stated that the home had not discussed any rationale as to why the resident was not wearing the protective equipment. The Inspector further reviewed the resident's health care record and was unable to find any documentation explaining why the protective equipment was not used on the resident the day the resident suffered a fall and an injury.

The Inspector was able to determine that resident #004 was not wearing protective equipment, as indicated on the plan of care, when the resident suffered a fall and an injury.

Log # 003295-17 [s. 6. (7)]

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 resident plans of care for falls management and repositioning are followed by the staff providing care to residents, to be implemented voluntarily.

Issued on this 16th day of February, 2017

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

Original report signed by the inspector.