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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 9, 2018	2018_559142_0010	028202-17, 028930-17, 005100-18, 008717-18, 019470-18, 020023-18, 023204-18	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

JANET MCPARLAND (142)

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 16, 17, 18, 19, 24, 25 and 26, 2018

The following intakes were inspected during this Critical Incident System Inspection:
Log #'s 028202-17 (CIR #2845-000019-17) and 020023-18 (CIR # 2845-000018-18)- related to alleged staff to resident abuse/neglect
Log #'s 028930-17 (CIR #2845-000020-17), 005100-18 (CIR #2845-000003-18), 019470 -18 (2845-000017-18), 023204-18 (2845-000021-18)-related to incident that cause an injury to a resident for which the resident is taken to hospital
Log # 008717-18 (CIR# 2845-000007-18)- related to resident to resident alleged abuse

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Education Co-ordinator, the Director of Care (DOC), and the Executive Director (ED).
The inspector also observed the provision of resident care and services, reviewed resident health care records, Licensee incident investigation notes and specific policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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	Légende 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 has failed to ensure that care was provided to the resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to MOHLTC regarding an incident that caused an injury to resident #002 for which the resident was taken to hospital. On an identified date, resident #002 was found lying on the floor and upon assessment resident was noted to have sustained an injury. Resident #002 was sent to hospital for further assessment and was diagnosed with a fracture.

Resident #002's plan of care in place at the time of the incident indicated that the resident was screened at high risk for a fall due to previous falls, dementia and impaired mobility and transfer. Interventions identified on the plan of care included the use of a specific intervention.

A review of resident 002's health care record identified that staff noted that at the time of the fall, resident #002 had in place a specific intervention but was not in use.
In an interview with the DOC, they confirmed that the staff member who provided care to resident #002 on an identified date did not implement the specified intervention.

The licensee failed to ensure that resident #002 received the care set out in the plan of care which resulted in resident falling and sustaining an injury. (log #005100-18).

WN #2: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

As per O.Reg. 79/10 s.114(1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The Licensee has in place a Medisystem policy titled 'Medication Reconciliation' (review date of January 17, 2017) which indicates that as part of the admission process a medication history from various sources (ie discharge list from hospital etc) is obtained. Once the medication history has been obtained it should be compared to the admission orders to identify any omission or changes in dosing, frequency and/or strength of medications.
The medication reconciliation policy further outlines the admission procedure includes the following:
-all medications should be written on the 'new admission order form' upon verification of orders by the physician.
-do not add orders to the admission order sheet once the approval section has been filled out. Use a regular physician's order and add to the MAR as per standard procedure.
-orders are to be verified and checked against the best possible medication history. Some facilities may choose to have a second nurse check to review and verify the processed orders.

Resident #005, was admitted to the home on an identified date. Upon admission a medication order was received for, an antibiotic, one tablet daily for seven days with an identified stop date. It was noted in the admission information received from the hospital that the resident had received the antibiotic for five days while in hospital and therefore an identified stop date was indicated on the new admission medication order form.

Upon review of the health record, it was noted that the physician, after speaking with the resident's family, changed the antibiotic order to continue daily for 30 days and reassess. The antibiotic order for seven days was crossed out and it was written for 30 days but the specific stop date was not crossed out. The order was electronically sent through to pharmacy by the digipen for 30 days with the specified stop date. It was noted on the medication administration record, that the resident received the antibiotic on two identified dates.

In a review of the DOC's email correspondence, to Pharmacy it was noted that the pharmacy did not have a copy of a physician order sheet that had the date of an identified stop date crossed out and therefore, the antibiotic was sent for two days and not for 30 days.
In an interview with RNs #101,102 and 103, they indicated that the expectation is that following the initial entry of the medication orders on the admission form, the orders are reviewed by two additional registered staff members, one working the evening shift and one from the night shift. At the bottom of the admission orders form there is a designated area whereby the nurses would acknowledge the review of the medication orders and sign either as Nurse #1 or Nurse #2.
In reviewing the new admission order form for resident #005, it was noted that there was one signature from the registered staff working the night shift.
In an interview with the DOC, they indicated that during the Licensee investigation into the medication incident it was noted that the RPN working on the evening shift did not review the admission orders. The investigation further found that the RN working the night shift, indicated that they reviewed the admission orders, but did not recall seeing the identified stop date crossed off and after reviewing the order again they indicated that it was a confusing order and that it should have been rewritten.

The Licensee failed to ensure that the Medication Reconciliation policy was complied with in regards to ensuring that changes to the admission medication orders were written on a regular physician's order and that admission medication orders were reviewed by a nurse on the evening shift.
(log #020023-18) [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.
For the purposes of the definition of "abuse" in subsection 2 (1) of the Act is as follows:
"emotional abuse" means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident
"verbal abuse" means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident
"neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents

On an identified date, a Critical Incident Report (CIR) was submitted to MOHLTC indicating that a staff member reported to management an allegation of a staff to resident abuse which occurred on an identified date.

The Licensee's Resident Non-Abuse policy in place at the time which the incidents occurred indicated that Revera has a zero tolerance for abuse and neglect and that any form of abuse or neglect by any person interacting with residents, whether through deliberate acts or negligence will not be tolerated. The policy further indicated that, anyone who becomes aware of or suspects abuse or neglect of a resident must immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on the shift.

During the Licensee's investigation into the allegation of abuse, staff members reported that on an identified date, a specific staff member was heard yelling at a resident to stay in bed and that they were going to call the police if the resident did not stay in bed. It was also reported during the same investigation that on an identified date a resident rang the call bell and staff reported that the same staff member told staff not to answer the call bell.
The Licensee's investigation into the incidents of alleged abuse/neglect determined that seven staff members who witnessed the incidents of abuse/neglect failed to immediately report the allegations as per the Licensee policy.

In an interview with the Executive Director, they confirmed that seven staff members did not report the allegations of abuse/neglect which occurred on identified dates until a staff member reported the allegations on an identified date.

The Licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with. (log #028202-17). [s. 20. (1)]

Issued on this 30th day of November, 2018

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

Original report signed by the inspector.