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_0008	025421-17, 025471-17	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): September 20 and 21, 2018.

The following intakes were completed during the complaint inspection:
-Log #025241-17-complaint related to resident care and
-Log #025471-17- critical incident report (#2845-000017-17) related to an incident that causes an injury to a resident for which the resident is taken to hospital

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), the Director of Care (DOC), and the Executive Director.
During the inspection, the inspector also observed the provision of resident care and services and reviewed a resident health care record.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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	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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Critical Incident Report #2845-000017-17 was submitted to MOHLTC regarding an incident that caused an injury to resident #001 for which the resident was taken to hospital and resulted in a significant change in the resident's health status.

On an identified date, two PSWs were transferring resident #001 using a mechanical lift when the resident's knees gave out and their feet came off the lift platform. The resident was supported by the sling and lowered to the floor at which time it was noticed that their feet became caught between the floor and the bedframe. Resident was assessed by RN # 100 and did not show any sign of injury or pain at that time.

On a specific date, the resident was noted to have a change in condition. Resident was assessed by physician on a specific date and diagnosed with a specific diagnosis and started on a specific medication. A telephone message was left with the resident's substitute decision maker (SDM). During a specific shift, resident was noted to have a change in condition. Physician was contacted and resident was transferred to hospital. Resident's SDM was notified of the transfer. On a specific date resident returned from hospital with a diagnosis of a fracture.

In reviewing the resident's health record, it was noted that the resident's SDM was not notified of the incident which occurred on a specific date.

On September 20, 2018 during an interview with RN#100, they confirmed that resident's SDM was not contacted on October 28th 2017 to inform them of the incident which occurred on that day.
In interviews with the Executive Director and Director of Care, both confirmed that the resident's SDM was not informed on the above noted incident.

Issued on this 9th day of November, 2018

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

Original report signed by the inspector.