Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Original Public Report

Report Issue Date: June 12, 2023

Inspection Number: 2023-1330-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: AXR Operating (National) LP, by its general partners

Long Term Care Home and City: Longfields Manor, Nepean

Lead Inspector	**Inspector Digital Signature**
Megan MacPhail (551)	Megan K MacPhail Digitally signed by Megan K MacPhail Date: 2023.06.30 14:17:30 -04'00'

Additional Inspector(s)
Mark McGill (733)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 9, 10, 11, 12, 16, 17, 18, 2023.
The inspection occurred offsite on the following date(s): May 15, 2023.

The following intake(s) were inspected:

- Intake: #00021464 / Critical Incident System (CIS) report 2845-000006-23 was related to an unexpected death.
- Intake: #00022050 was a complaint related to the fall of a resident.
- Intake: #00022627 / CIS report 2845-00008-23 was related to an unexpected death.
- Intake: #00085422 / CIS report 2845-000010-23 was related to a fall that resulted in a significant change in the resident's health status.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident's plan of care set out clear directions for staff.

1) Rationale and Summary

A Plan of Treatment for CPR existed for a resident. The plan indicated that CPR would be performed in the event of a witnessed cardiac arrest. A Do Not Resuscitate (DNR) Confirmation form was not signed.

A Palliative and End-Of-Life Medication Order Set was signed for the resident.

When the resident had a change in health condition, the Charge Nurse was called to the home area. The Charge Nurse stated that CPR was written on the spine of the resident's physical chart, and they called a code blue. Staff who responded to the code stated that palliative care orders were in place, and comfort care was the goal.

The resident had a Plan of Treatment for CPR in place, and on the spine of the resident's chart, CPR was written. Palliative and End-of-Life orders were in place. The resident's plan of care did not set out clear directions to staff with regards to CPR and palliative care.

Sources: A resident's health care record and interview with a Charge Nurse.

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2) Rationale and Summary

A resident's plan of care specified a target blood pressure.

As part of an assessment, the resident's blood pressure was being checked at specific intervals. During

the checks, the resident's blood pressure did not meet the target several times.

The ADOC stated that with some orders there was direction to notify the physician if the target was not met. With this order, they stated that there was no direction regarding action to be taken should the blood pressure not meet the target

The plan of care did not provide direction to follow for when the target blood pressure was not met.

Sources: A resident's health care record and interview with ADOC.

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WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

One to one monitoring was implemented for a resident, and the expectation was that the resident was monitored at all times.

A PSW was assigned to the one to one monitoring. They were in the doorway of the resident's room and checking on the resident frequently. While the PSW went for lunch, the other PSWs assigned to the area, checked in on the resident, but did not provide constant monitoring.

When the RPN entered the resident's room, the resident was found to have had a change in health condition.

The plan of care for the resident included one to one monitoring at all times. While the assigned PSW was at lunch, the resident's health condition changed. The change in health condition was not witnessed.

Sources: A resident's health care record and interviews with staff.

[551]

WRITTEN NOTIFICATION: Falls Prevention and Management Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that the Falls Prevention and Management policy was complied with.

Rationale and Summary

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to have a falls prevention and management program to reduce the incident of falls and the risk of injury, and it must be complied with.

Specifically, staff did not comply with the Post-Fall Management procedure and the Head Injury Routine Procedure, which were included in the licensee's Fall Prevention and Injury Reduction Program, in effect when the resident fell.

The Post-Fall Management procedure directed: If a fall is un-witnessed or the Resident was witnessed hitting his/her head during the fall, the Head Injury Routine is initiated, and Neurovitals are monitored for 72 hours. The Head Injury Routine directed to follow the frequency of observation as per Neurological Flowsheet or as determined by the physician or regional requirement.

A resident had an unwitnessed fall. Head Injury Routine (HIR) was initiated and completed at specific intervals until the resident was sent to hospital. They returned on the same day.

HIR was not completed and neurovitals were not monitored upon the resident's return from hospital and on several shifts afterwards.

The ADOC reviewed the resident's HIR sheet and stated that HIR was not completed at the specific intervals required by the HIR.

By not completing HIR and monitoring the resident's neurovitals, staff may not have been able to determine if the resident was stable or if there was a change in their vital signs and/or neurological assessment, or if they developed specific symptoms, which as per the HIR warranted a call to the physician.

Sources: A resident's health care record and interview with ADOC.

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WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

1) The licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

The resident was ordered a medication at specific intervals.

When a dose was due, the eMAR showed that the medication was not administered. No progress note was written to indicate why the medication was not administered or what the follow-up would be.

The ADOC reviewed the resident's health care record and stated that the medication was not administered as ordered, and there was no progress note written in follow-up.

The resident was prescribed doses of a medication at specific intervals, and the medication was not administered as prescribed.

Sources: A resident's health care record and interview with the ADOC.

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2) The licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident was ordered a medication to treat a health condition.

The resident's health care record indicated that there was discussion of changing the medication to one that could be crushed, and therefore the initial dose was not given.

An RPN stated that the resident took their medication whole. They administered the first dose of the medication in the form of a capsule as ordered.

Not administering the medication as prescribed meant that there was a delay in initiating the treatment.

Sources: A resident's health care record and interview with an RPN.

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