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: August 14, 2023

Inspection Number: 2023-1330-0003

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**
Gurpreet Gill (705004)	Gurpreet K Gill Digitally signed by Gurpreet K Gill Date: 2023.09.06 10:33:34 -04'00'

Additional Inspector(s)
Dee Colborne (000721)
Jessica Nguyen (000729)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 22, 23, 28, 29, 30, 2023
The inspection occurred offsite on the following date(s): June 27, 2023

The following intake(s) were inspected:
- Intake: #00087675 - CI: 2845-000014-23 – related to provision of care and services
- Intake: #00088285 - CI: 2845-000018-23 – related to a fall incident that caused injury to a resident
- Intake: #00089107 - CI: 2845-000019-23 – related to alleged staff to resident abuse
- Intake: #00089512 - CI: 2845-000020-23 – complaint from family forwarded by home regarding accommodation and communication with the family
- Intake: #00089082 - complaint related to care and services to a resident
- Intake: #00089520 - complaint related to accommodation and communication with the home.

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

Resident Care and Support Services
Infection Prevention and Control

Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management
Admission, Absences and Discharge
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control, specifically related to the point-of-care signage indicating that enhanced IPAC control measures are in place as is required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary

On June 22, 2023, the inspector observed that the resident had personal protective equipment (PPE) supplies at the room entrance but there was no signage posted at the entrance to the resident's room or bed space indicating that enhanced IPAC measures were in place for residents on additional precautions.

The Registered Nurse (RN) indicated that the resident was on contact precautions and the signage may have been misplaced.

On June 23, 2022, the inspector observed that signage for contact precautions was posted at the entrance to the resident's room.

There was no impact and low risk to the resident as the signage was posted as soon as the licensee was aware of the non-compliance.

Sources: Interview with the RN and observations made by the inspector. [705004]

Date Remedy Implemented: June 23, 2023

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 home failed to ensure that the plan of care was followed as set out in the plan of care.

Rationale and Summary

A resident was observed by the inspector, in the unit dining room seated in their mobility device. It was observed that an identified external device was dangling on the left side of the mobility device, unfastened. The resident was also observed on several occasions, sitting in the TV lounge and the identified external device was not secured.

Upon review of the resident's plan of care, it was noted that the identified external device was to be applied at all times.

The use and application of the identified external device was communicated to staff via a unit device list located at the nursing station.

An interview with a PSW confirmed that the resident doesn't wear a device.
An interview with another PSW confirmed that the resident doesn't wear a device and never has.
An interview with an RPN confirmed that the resident's plan of care states resident is to wear the identified external device and also demonstrated to Inspector the list of residents with devices posted on the nursing board in the nursing office.

Failure to follow the plan of care places the resident at a greater risk of falls.

Sources: The resident's health care record and Interview with an identified staff member. [000721]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented for three residents.

Rationale and Summary

The residents were scheduled to receive a bath or shower twice weekly, as per their plan of care.

The point of care (POC) documentation for a resident showed that for the month of May 2023, there was one day where the resident's bath was not documented.

The point of care (POC) documentation for another resident showed that for the month of May 2023, no baths were documented, and for the month of June 2023 there were two days where the resident's baths were not documented.

The point of care (POC) documentation for another resident showed that for the month of June 2023, there was one day where the resident's bath was not documented.

During an interview, the Assistant Director of Care (ADOC) indicated that residents received their scheduled biweekly baths but the staff did not complete their documentation in the POC. Therefore, the provision of care set out in the three residents' plan of care regarding the bath was not documented.

Sources: Residents' health care records and interview with the ADOC. [705004]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (2) 2.

The home failed to ensure staff followed the Physicians' order in regards to the application of a device.

Rationale and Summary

A resident was observed by the inspector, in the unit dining room seated in their mobility device. It was observed that an identified external device was dangling on the left side of the mobility device, unfastened. The resident was also observed on several occasions, sitting in the TV lounge and the identified external device was not secured.

Upon review of the resident's plan of care, it was noted that the identified external device was to be applied at all times.

Upon review of the resident's physician orders, there was an order to have the identified external device applied for safety and fall prevention.

The use and application of the identified external device was communicated to staff via a unit device list located at the nursing station.

An interview with a PSW confirmed that the resident doesn't wear a device.
An interview with another PSW confirmed that the resident doesn't wear a device and never has.

An interview with an RPN confirmed that the resident's plan of care states resident is to wear the identified external device and also demonstrated to Inspector the list of residents with devices posted on the nursing board in the nursing office.

Failure to follow the physician's order places the resident at a greater risk of falls

Sources: The resident's health care record and Interview with an identified staff member. [000721]