Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 24, 25, 26, 27, 28, 2012	2012_030150_0027	Critical Incident

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

CAROLE BARIL (150)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director Care, Registered Nurse, Registered Practical Nurse, Personal Support Worker and resident.

During the course of the inspection, the inspector(s) reviewed two identified residents' health care records, the home's Fall Assessment policy/procedure #LTC-D-10A dated January 2006, the Doctor's communication book, observed the staff-resident interaction and residents activities.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCA 2007, section 24 (1), in that a critical incident related to a resident to resident abuse causing injury was not immediately reported to the director.

In September 2012, the progress notes indicates that the resident #1 was found sitting on the floor in her/his room. The resident told the staff that the resident #2 had pushed her/him and the resident fell to the floor and hit her/his head. The registered staff found a head injury, cool compresses were applied and head injury monitoring initiated.

The Director of Care states that she was informed on a specific date in September 2012 in the evening of the resident to resident abuse incident and confirms that the registered staff did not inform her that the resident #1 had an injury post fall.

The critical incident report #2845-000030-12 of alleged abuse with injury was submitted to the Director 3 days after the incident in September 2012.

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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s.8 (1) (b), in that the home's Fall Assessment policy/procedure was not followed.

As per O.Reg section 49 (2) The licensee's Fall Assessment policy #LTC-D-10A dated January 2006, under the Fall Prevention Program, section 9 states "Notify physician of fall: immediately with a critical injury and during the day if no injuries & or resident status is stable. Put a note in the physician communication book regarding the fall and status of resident. Physician to visit " and section 10 "Document on notification of physician on the chart"

In September 2012, the resident #1 was found sitting on the floor in her/his room. The resident told the staff that the resident #2 pushed her/him and the resident fell to the floor and hit her/his head. The registered staff found a head injury, cool compresses applied and head injury monitoring initiated.

"Doctors Rounds" communication book indicates "Resident #1 sustained head injury from fall, pushed by resident #2, police notified "

Reviewed the progress note of resident #1 for September 2012, no documentation found related to communication with the physician regarding the resident#1 fall and injury.

Reviewed the head injury monitoring flow sheet for September 2012 indicating that the Glasgow Coma Scale assessment of the resident was unchange.

In September 2012, the progress notes indicates that "the resident #1 was c/o headache, voice little hoarse, vomited small amount brownish emesis". The physician was not informed of changes in the resident's status.

On a specific date in September 2012, the resident had a seizure and the physician was informed and ordered resident #1 to be transferred to the hospital for assessment.

The Director of Care states that she was informed on a specific date in September 2012 in the evening of the incident and confirmed that the registered staff did not inform her that the resident #1 had an injury post fall.

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 by ensuring that the Fall assessment policy/procedure is followed., to be implemented voluntarily.

Issued on this 28th day of September, 2012

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