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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 15, 2014	2014_288549_0023	O-000275-14	Resident Quality Inspection

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

RENA BOWEN (549), KATHLEEN SMID (161), LINDA HARKINS (126), MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 6, 7, 8, 9, 10, 12, 13, 14, 2014

During the course of the inspection, the inspector(s) also conducted a Critical Incident inspection log# O-000334-14.

During the course of the inspection, the inspector(s) spoke with Residents, the President of the Residents' Council, President of the Family Council, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), Dietary Aides, Housekeeping Aide, Environmental Service Manager (ESM) ,Food Service Supervisor (FSS), Resident Service Coordinator (RSC) , RAI MDS Coordinator, Regional RAI MDS Coordinator, Activation Coordinator, Director of Care (DOC) and the Executive Director (ED).

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records,Licensee policies and procedures, staff work routines, posted menus, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed a medication pass, observed one meal service, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007,S.O. 2007, c.8, s.3(1)1 in that the licensee did not ensure that four Residents were treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On May 13, 2014 at 13:30 hours, Inspectors #161 and #549 observed that Resident #765, who is dependent for care, was lying in his/her bed, covered with a blanket, with his/her pants pulled down to his/her knees exposing his/her continence product. The Resident's most recent care plan dated 3-18-2014 was reviewed and it does not indicate that this is the Resident/SDM's preference when having an afternoon nap.

On May 13, 2014 at 13:32 hours, Inspectors #161 and #549 observed that Resident #004, who is dependent for care, was lying in his/her bed, covered with a blanket, with his/her pants pulled down to his/her knees exposing his/her continence product. The Resident's most recent care plan dated 2-27-2014 was reviewed and it does not indicate that this is the Resident/SDM's preference when having an afternoon nap.

On May 13, 2014 at 13:35 hours, Inspectors #161 and #549 observed that Resident #006, who is dependent for care, was lying in his/her bed, covered with a blanket, with his/her pants pulled down to his/her knees exposing his/her continence product. The Resident's most recent care plan dated 2-20-2014 was reviewed and it does not indicate that this is the Resident/SDM's preference when having an afternoon nap.

On May 13, 2014 at 13:37 hours, Inspectors #161 and #549 observed that Resident #007, who is dependent for care, was lying in his/her bed, covered with a blanket, with his/her pants pulled down to his/her knees exposing his/her continence product. The Resident's most recent care plan dated 3-26-2014 was reviewed and it does not indicate that this is the Resident/SDM's preference when having an afternoon nap.

On May 13, 2014 at 14:05, Inspector #161 discussed these observations with the Director of Care. She indicated to the Inspector that this was not acceptable practice and that she would address it. [s. 3. (1) 1.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007,S.O. 2007, c.8, s. 15(2) in that the home's equipment was not kept clean. Throughout this inspection Inspectors #161 and #551 observed that there were several unclean Resident wheelchairs and walkers.

During the inspection, Inspectors #551 and #161 observed the following:
Resident 765: The wheelchair arm rest was dusty and contained food debris.
Resident 726: The wheelchair leg and arm rests and foot pedal were soiled.
Resident 803: The wheelchair seat cover was soiled.
Resident 781: The wheelchair seat cover had debris on it.
Resident 825: The wheelchair table top was dusty and soiled. The wheel chair seat was soiled.
Resident 768: The walker seat was soiled.
Resident 727: The wheelchair arm rest and seat was soiled. [s. 15. (2) (a)]

2. The licensee has failed to comply with LTCHA 2007,S.O. 2007, c.8, s. 15 (2) (c)in that the licensee did not ensure that the home, the furnishings and equipment are in a good state of repair.

During this inspection the following was observed in Beatrice Unit: the walls in the tub and shower room have peeling paint and wall paper, rust on the trap door opening on the wall beside the sink; the shower room has a deep crack in the wall beside the toilet, damaged gyprock to the left of the mirror, rust noted along the baseboard metal capping strip, the corner metal beading is exposed on one wall.
The finish on the arms and legs of several wooden chairs throughout the home is worn off. Resident 768's walker arm rests were cracked and a piece of metal was protruding through the arm rest creating a safety hazard. [s. 15. (2) (c)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg.79/10 s. 49. (2) in that the licensee did not conduct a post-fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls.

Resident #005 was admitted on a specified date February,2013. Upon review of Resident #005's health record it was noted that between August, 2013 and February, 2014 Resident #005 fell nine times. Resident # 005 sustained a hip fracture after the February fall.

A quarterly Falls Risk Assessment Tool (FRAT) was completed March 12, 2013.

On May 13, 2014 during an interview RN S#100 stated to Inspector #549 that the Falls Risk Assessment Tool (FRAT) is the clinically appropriate instrument used by the home for residents after each fall. The FRAT was not completed following any of the nine falls between August, 2013 and February , 2014.

On May 13, 2014 the DOC confirmed to Inspector # 549 and Inspector #161 that the FRAT is the clinically appropriate assessment instrument used by the home for residents after each fall.[Log# O-000334-14] [s. 49. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 71 (3) (b) in that the licensee did not ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

During stage one of the Resident Quality Inspection (RQI), 3 interviewed residents stated that they were not offered a between-meal beverage in the morning, the afternoon, and in the evening after dinner.

On May 14, 2014 the Food Service Supervisor indicated to Inspector #551 that the between-meal beverage pass times are between 10:00-10:30 in the morning, 14:30-14:45 in the afternoon and 19:30-20:00 in the evening.

On May 9, 2014, Inspector#551 arrived on Beatrice Terrace at 09:52 and spoke with staff member S#103 who showed Inspector# 551 the nourishment cart that would be used for the morning between-meal beverage pass. Inspector#551 was seated at the nursing station within sight of the nourishment cart and kitchen. No fluids were observed to be poured and offered to residents. At 10:46 the nourishment cart remained in the kitchen servery area and had not been circulated to the residents.

On May 9, 2014 at 10:40, Inspector# 549 went to Parkview Terrance and asked Resident #011 if a beverage between breakfast and lunch was offered, and was told "usually", but Resident #011 stated that a beverage had not been offered on that day. Inspector#549 toured Parkview Terrace and did not observe the nourishment cart being circulated or residents being offered a between meal beverage.

On May 12, 2014, staff member S#114 was interviewed and stated that there are times when the between-meal beverage in the morning is not offered to the residents. Staff member S#114 stated this occurred "once every two weeks". On May 12, 2014, when asked about the between-meal beverages not being given to residents the Food Services Supervisor indicated to Inspector #551 that if the between-meal beverages were not offered it would be the morning between-meal beverage pass. The Food Service Supervisor stated that the afternoon and evening nourishments were consistently offered. [s. 71. (3) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007,S.O. 2007, c. 8, s. 85 (3) in that the licensee does not seek the advice of the Family Council in developing the satisfaction survey.

The 2013 satisfaction survey was conducted from June to August according to the minutes of the Home's Family Council meeting held on November 19, 2013.

On May 12, 2014, the President of the Family Council was interviewed and stated that the licensee does not seek the advice of the Family Council in developing the satisfaction survey.

The minutes of the 2013 and 2014 Family Council meetings were reviewed, and there is no documentation to support that the licensee sought the advice of the Family Council in developing the satisfaction survey. On May 14, 2014, the Executive Director was interviewed and stated that the advice of the Family Council was not sought in developing the 2013 satisfaction survey. [s. 85. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 107 (3)4 in that the licensee did not notify the Director of an incident that caused an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

On a specified date in February, 2014 Resident #005 was found on the bathroom floor. Resident #005 was subsequently sent to hospital that same day.

A Critical Incident Report was completed and describes Resident #5's injuries as: "right temporal lobe with a large amount of blood on his/her head and fingers and pain in his/her back and right hip". On a specified date in February, 2014 Resident #5's daughter informed the home that Resident #5 had sustained a fractured a right hip and was awaiting surgery.

The home notified the Director through the Critical Incident System two days after becoming aware of the incident.[Log# O-000334-14] [s. 107. (3) 4.]

Issued on this 16th day of May, 2014

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

Rena Bowen #549
Megan McPhail #551
LINDA HARKINS # 126
Kathleen Smid # 161