



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

**Rapport d'inspection
prévus le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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**Ministère de la Santé et des Soins de
longue durée**

Division de la responsabilisation et de la performance du
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Date of inspection/Date de l'inspection October 13, 2010	Inspection No/ d'inspection 2010-137-2878-13Oct085830	Type of Inspection/Genre d'inspection Complaint L-01412
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Licensee/Titulaire
Devonshire Erin Mills Inc., 195 Dufferin Avenue, Suite 800, London, ON N6A 1K7

Long-Term Care Home/Foyer de soins de longue durée
Longworth long-Term Care Facility, 590 Longworth Road, London, ON N6K 4X9

Name of Inspector/Nom de l'inspecteur
Marian C. Mac Donald - # 137

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Complaint inspection related to a fall and care provision.

During the course of the inspection, the inspector spoke with: Administrator, DOC, ADOC, Registered staff.
PSW's and family members.

During the course of the inspection, the inspector: observed resident, reviewed MARS, plan of care, progress
notes, assessments and Emergency Dept. report.

The following Inspection Protocols were used during this inspection:
Critical Incident Response, Falls Prevention, Pain and Personal Support Services.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN
4 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)

**6(1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
 (c) clear directions to staff and others who provide direct care to the resident.**

Findings: The plan of care for an identified resident did not give clear directions to staff as evidenced by the following contradictory directions:

- 1. Aids to Daily Living – Fully independent with devices. One side rail only. Ensure using walker as required. Encourage to propel wheelchair with her feet. The resident has been in bed since a fall and is unable to use walker or wheelchair.**
- 2. Sleep and Rest – Attempts to get out of bed. Two side rails at all times.**
- 3. Safety Devices/Restraints – Full bed rails on all open sides of bed, used daily.**
- 4. Skin Integrity – Extensive bruising from the recent fall and swelling of left knee were not identified.**
- 5. Comfort – Subcutaneous butterfly infusion for medication administration or comfort measures were not identified.**

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, related to ensuring written plan of care gives clear directions to staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O. Reg. 79/10, s.26(3)(10)

26(3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

(10) Health conditions, including allergies, pain, risk of falls and other special needs.

Findings: For an identified resident, the plan of care indicates the following contradictory information:

- 1. Resident is at low risk for falls, however, resident has a history of falls and sustained a fracture, in the past.**
- 2. Resident can be unsteady on feet, requires assistance and attempts to climb out of bed.**
- 3. A Falls Risk Assessment has not been completed since the recent fall or return from hospital visit.**

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, related to assessments, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O. Reg. 79/10, s.107(3)(4)

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.

Findings:

1. A resident fell sustained an injury and was sent to hospital for assessment.
2. The Director was not notified of the incident no later than one business day after the occurrence.
3. The Critical Incident report was submitted on the day of the inspection.

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, related to reporting critical incidents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.76(2)(5)

76(2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the area mentioned below:

(5) The protections afforded by section 26.

Findings: Staff does not receive training in the area of "whistle blowing" protections afforded under section 26, prior to performing their responsibilities.

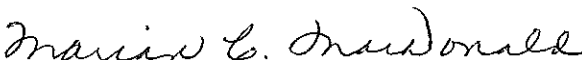
1. Registered staff and PSW's were not aware of whistle blowing protection in the legislation.
2. ADOC, responsible for staff orientation and in-service education, shared that "whistle blowing" protection training is not currently being provided during orientation.

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, related to "whistle blowing" protections training, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné

Signature of Health System Accountability and Performance Division
representative/Signature du (de la) représentant(e) de la Division de la
responsabilisation et de la performance du système de santé.



Title:

Date:

Date of Report: October 19, 2010