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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 5, 2015	2015_349590_0003	L-001767-15	Resident Quality Inspection

Licensee/Titulaire de permis

LAPOINTE-FISHER NURSING HOME, LIMITED
1934 DUFFERIN AVENUE WALLACEBURG ON N8A 4M2

Long-Term Care Home/Foyer de soins de longue durée

FAIRFIELD PARK
1934 DUFFERIN AVENUE WALLACEBURG ON N8A 4M2

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

ALICIA MARLATT (590), CAROLEE MILLINER (144), TERRI DALY (115)

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): January 19, 20, 21, 22 and 23, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Director of Nutritional Services, the Director of Activation, the Environmental Services Supervisor, the Resident Care Plan Coordinator, a Registered Physiotherapist, a Registered Occupational Therapist, a Maintenance staff member, a Restorative Aide, two Dietary Aides, two Registered Nurses, five Registered Practical Nurses, nine Personal Support Workers, the President of the Residents Council, 40 Residents and three family members. The Inspector(s) toured all resident home areas, observed dining services, medication rooms, medication administration, the provision of resident care, recreational activities, staff/resident interactions, infection and prevention control practices and reviewed resident clinical records, posting of required information, meeting minutes related to inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan as evidenced by:

The written plan of care for resident #001 identifies a specific toileting plan.
A person advised they are present in the home often and that they have not seen the resident toileted or their incontinent product checked during their visits.
Nursing personnel indicated the resident is toileted fewer times than the planned toileting schedule.
The Director of Care confirmed the care set out in the plan of care is not provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan as evidenced by:

The written plan of care for resident #002 identifies the resident uses a specific type of restraint and that registered staff are required to document the use of the restraint every 8 hours.
The restraints were observed by Inspector #144, to be in use with the resident on four occasions between January 21 and 22, 2015.
Two registered staff confirmed registered staff do not document the use of this type of restraint as they are not considered to be restraints.
The two registered staff further confirmed the resident is restricted in movement when the restraint is used.
The home's Restraint Policy, revised March 2012, does not include this specific restraint as a restraint.
One manager advised that this particular restraint is not considered a restraint, however, when the plan of care includes a directive for monitoring their use, registered staff are required to follow the plan of care. [s. 6. (7)]

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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with as evidenced by:

Resident #001 had an unwitnessed fall.
The homes "Fall Prevention and Management Program" policy, last reviewed February, 2011, includes a directive for Registered Staff to complete a Resident Incident Report when a fall occurs and to keep the report in the resident's 's health record.
The resident's health record does not include an incident report for the fall.
One nursing staff & management personnel confirmed the "Fall Prevention and Management" policy was not followed and an incident report was not completed after the resident fell. The management personnel confirmed it is the homes expectation that their Fall Prevention and Management policy is followed. [s. 8. (1) (a)]

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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that the windows in the home that open to the outdoors and are accessible to residents cannot be opened more than 15 cm.

During Stage 1 of the RQI the inspector observed an open window in the sitting area at the end of the Blue wing hall. Upon inspection the window could be opened greater than 15 cm. Several other windows of the same design were checked in the Blue and Green home areas and could be opened more than 15 cm.
Windows in the Courtyard home area have all been modified to ensure the opening is no more than 15 cm.

The Administrator confirmed with Inspector #590 that this type of window could be found throughout the building.
An interview with the maintenance staff member confirmed that the windows could be opened greater than 15 cm in the Blue and Green units and the front activity area.
The home advised that Erie Glass have been notified and that a solution to apply a stopper in each window would hopefully rectify the situation.

It is the home's expectation that for resident safety, windows accessible to residents cannot be opened more than 15 cm. [s. 16.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #41 has a pressure ulcer.
The Homes policy titled "Skin Care and Wound Management - Assessment and Interventions" indicates that "When wounds, blisters, pressure areas or skin tears are identified, initiate the "Weekly Wound/Skin Record & Assessment" form. An assessment of the wound must be done weekly, using this form until wound is healed".
Review of Resident #41 Weekly Wound/Skin Record & Assessment forms for a four month period revealed that wound assessments were not completed or documented 33% of the time.
The Administrator confirmed the homes expectation is that registered staff are to complete weekly wound assessments and document the assessment on the Weekly Wound/Skin Record & Assessment form. [s. 50. (2) (b) (iv)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #42 has pressure ulcers.
The Homes policy titled "Skin Care and Wound Management - Assessment and Interventions" indicates that "When wounds, blisters, pressure areas or skin tears are identified, initiate the "Weekly Wound/Skin Record & Assessment" form. An assessment of the wound must be done weekly, using this form until wound is healed".
Review of Resident #42 Weekly Wound/Skin Record & Assessment forms for a four month period revealed that wound assessments were not completed or documented 33% of the time for both wounds.
The Administrator confirmed the homes expectation is that registered staff are to complete weekly wound assessments and document the assessment on the Weekly Wound/Skin Record & Assessment form. [s. 50. (2) (b) (iv)]

Issued on this 6th day of February, 2015

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

Original report signed by the inspector.