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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jul 7, 2016	2016_349590_0016	018131-16	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), NANCY SINCLAIR (537), NATALIE MORONEY (610), SHERRI COOK (633), 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): June 21 - 24 & 27 - 30, 2016.

The following Critical Incidents were inspected concurrently:

Log #022911-15/CIS #2823-000019-15 was related to falls prevention.
Log #017071-15/CIS #2823-000015-15 was related to alleged abuse.
Log #008817-16/CIS #2823-000003-16 was related to maintenance services.
Log #018207-16/CIS #2823-000004-16 was related to falls prevention.
Log #030568-15/CIS #2823-000021-15 was related to falls prevention.
Log #018656-16/CIS #2823-000010-16 was related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Resident Care Plan Coordinator, the Director of Nutritional Services, the Maintenance Supervisor, the Activities Director, the Director of Environment/Education/Social Services, an Activation Behavioural Supports Ontario staff member, two Registered Nurses (RN), seven Registered Practical Nurses (RPN), 13 Health Care Aides (HCA), one Nurses Aide, two Dietary Aides, the Residents' Council President and 40+ Residents and three Family members.

During the course of the inspection, the inspector(s) reviewed seven Critical Incident reports, 40 resident clinical records, relevant policies and procedures and Resident and Family Council meeting minutes.

During the course of the inspection, the inspector(s) observed the dining service, medication storage areas and administration, resident/staff interactions, toured the resident home areas, viewed the required posted information, the provision of resident care, recreational activities and infection control practices.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **4 WN(s)**
- **4 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. 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential.

During an observation of the East and West dining rooms on June 21, 2016, Inspector #610 observed Personal Health Information (PHI) secured on the dining room tables in front of each resident's place at their tables. The information secured to the tables included resident names along with their type of dietary restrictions, allergies, and diagnosis.

The homes policy titled "Confidentiality - Employess/Volunteers/Co-Op Placement Students", last revised in December 2014, indicated that:

"Information regarding residents and their current condition is confidential and may be released only to the Substitute Decision Maker (SDM) for Personal Care with the consent of the resident if capable."

The Director of Nutritional Services #112 said that the PHI should be confidential and the home was to maintain confidentiality regarding resident health conditions and had not ensured PHI was kept confidential. [s. 3. (1) 11. iv.]

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 every resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004, is kept confidential, to be implemented voluntarily.

WN #2: 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. (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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 written plan of care for each resident included the goals the care was intended to achieve.

Resident #070 was observed over a two day period and was seen in their wheelchair with assistive devices in place.

Interviews with Resident Care Plan Coordinator #105, Activation/Behavioural Support Ontario team member #127 and RPN Supervisor #111 indicated that resident #070 used the assistive devices at least once a day for comfort and repositioning.

Record review of resident #070's current care plan on Point Click Care (PCC) indicated that the assistive devices were at family request and the devices were not included as a goal or intervention.

Interview with the Resident Care Plan Coordinator #105 verified that the expectation would be that the care plan for resident #070 included the devices with the goal of providing the resident comfort and for repositioning. [s. 6. (1) (b)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #042 was observed during stage one of the Resident Quality Inspection (RQI) to be using assistive devices while up in their wheelchair. Interview with the resident revealed the resident could remove or adjust the devices on their wheelchair

independently; they were also able to demonstrate this to the inspector.

Review of resident #042's current care plan revealed no indication that this resident uses assistive devices while in their wheelchair independently.

In an interview with HCA #128 they indicated the care plan would be clearer for new staff coming on if it included that the resident used assistive devices.
In an interview with the DOC #118 she confirmed the assistive devices for this resident were not included in the care plan. The DOC indicated the home did not feel the resident needed the devices. The DOC also indicated the use of the devices on the wheelchair were requested by the resident and the resident's family for safety and comfort. [s. 6. (1) (c)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001 was observed by Inspector #610, in their room on the commode, and left unattended.

Resident #001’s plan of care for toileting showed that the resident had cognitive and physical impairments and required extensive assistance of two staff members for the entire process.

The homes policy regarding lifts indicated:

"A resident is never to be left unattended or left attached to the lift" and to "Release brakes and transfer the resident to new position such as toilet, wheelchair, chair or bed and remove the sling from the resident."

In an interview with HCA #116, they said that the resident had been left unattended on the commode chair attached to the lift.

The DOC #118 said that the resident should not have been attached to the sling and unattended during toileting and that the resident’s plan of care showed they were to be with two staff for the entire process and had not been. [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 plan of care set out clear directions to staff and others who provide direct care to the resident and 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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #041 had been identified as a high nutritional risk and having signs of dehydration.

Review of the Daily Food and Fluid Intake Record for a four month time period revealed missing documentation on 14% of the required entries.

Review of the home's policy titled "Hydration Management - Facility Program", last revised in August 2008, revealed that the HCA's are responsible to "Ensure that fluids consumed are monitored and recorded accurately at each of the meals and snacks and recorded in units."

Another policy reviewed, titled "Meal Tracking", was last revised in December 2008, and indicated that "All foods and fluids consumed by the resident are included and documented in as much detail as possible."

Interview with the Director of Nutritional Services #112 revealed HCA staff are to document on the Daily Food and Fluid Intake Record after each meal and snack indicating what each resident ate and drank. She confirmed that documentation was incomplete and did not accurately reflect what resident #041 had ate or drank. [s. 30. (2)]

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 actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: 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 failed to ensure when a resident had fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The home submitted a Critical Incident Systems report to the Ministry of Health and Long-Term Care which indicated that resident #018 had a fall with an injury and was taken to the hospital with a significant change in health status.

A review of PCC documentation showed that the resident had a fall, and there was no documented evidence to support that a post-fall assessment was conducted [s. 49. (2)]

2. The home submitted a Critical Incident Systems report to the Ministry of Health and Long-Term Care which indicated that resident #003 had a fall with an injury and was taken to the hospital.

A review of PCC documentation showed that the resident had a fall, and there was no documented evidence to support that a post-fall assessment was conducted.

The homes policy titled "Falls Prevention and Management" last revised in June 2015, revealed staff were to:

"Complete a falls risk assessment on admission/readmission, quarterly, annually or after any significant change in resident status and post falls."

The Resident Care Plan Coordinator #105 said that resident #003 did have a fall and should have had a completed post fall assessment and did not. The Resident Care Plan Coordinator #105 also said that resident #018 did have a fall, and should have had a completed post fall assessment and did not. [s. 49. (2)]

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 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, to be implemented voluntarily.

Issued on this 3rd day of August, 2016

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

Original report signed by the inspector.