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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 17, 2017	2017_563670_0027	024856-17	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

DEBRA CHURCHER (670), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): Nobember 6, 7, 8, 9 and 10, 2017.

The following Complaints and Critical Incident System (CIS) reports were inspected during this Resident Quality Inspection;
Log# 006841-17 IL#50135 Complaint related to alleged improper care
Log#032303-16 CIS#2823-000016-16 related to a fall with injury
Log#018208-16 CIS#2823-000005-16 related to a fall with injury
Log#034834-16 CIS#2823-000020-16 related to a fall with injury
Log#001431-17 CIS#2821-000003-17 related to a fall with injury
Log#029514-16 CIS#2823-000014-16 related to an injury of unknown origin

During the course of the inspection, the inspector(s) spoke with more than forty residents, the Administrator, the Director of Nursing, the Resident Assessment Instrument Coordinator, the Residents' Council representative, one Pharmacist, one Pharmacy Educator, one Nurse Supervisor, two Registered Nurses, four Registered Practical Nurses, eight Personal Support Workers, one Activation Director and three family members.

During the course of the inspection, the inspectors toured all resident home areas, medication rooms, medication administration and medication count, observed the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices, general maintenance and cleanliness of the home, and reviewed resident clinical records, posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

- **3 WN(s)**
- **3 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. (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 plan of care set out clear directions to staff and others who provided direct care to the resident.

A complaint was filed through the Ministry of Health and Long-Term Care Infoline, on a specific date, concerning specific care needs, of a specific resident.

In an interview, a Personal Support Worker (PSW) stated that the resident received specific care at specific times and would also independently participate at times. The PSW also stated that despite the care provided it was not effective. The PSW stated that the specific instructions related to this care need could be accessed in a specific area on the unit as well as the resident's care plan.

Review of specific staff direction, for the specific care need of the resident for a specific time frame was compared to the resident's care plan. The Inspector noted that the instructions outlined on the specific staff direction and the resident's care plan did not match.

Director of Nursing (DON) stated each of these pieces of documentation should match so that staff had clear direction on the care required for the resident.

The licensee has failed to ensure that there was a written plan of care for the resident

that set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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

A) A complaint was filed through the Ministry of Health and Long-Term Care Infoline, on a specific date, concerning specific care needs, of a specific resident.

Review of the plan of care for the resident, under a specific focus indicated the use specific equipment, with an specific initiation date.

Review of the resident's progress notes for a specific time frame stated that on two specific dates the equipment had not been used properly.

On November 8, 2017, a Registered Practical Nurse (RPN) stated that equipment should be used properly and should be used at specific times.

On November 8, 2017, the resident was observed without the required equipment in place.

On November 8, 2017, a Personal Support Worker (PSW) stated that the resident should have had the equipment in place.

On November 8, 2017, Director of Nursing (DON) stated that care should have been provided to the resident as specified in the plan.

B) A complaint was filed through the Ministry of Health and Long-Term Care Infoline, on a specific date, concerning specific care needs, of a specific resident.

Review of the resident's care plan showed a focus of a specific care need, effective on a specific date with specific interventions documented that included who was to provide the care, when the care was to be provided and where it was to be documented.

Review of the electronic Treatment Assessment Record (eTAR) for a specific time frame, did not include the required documentation that the resident received the specific care on four separate occasions.

Review of documentation in Point Click Care (PCC) on a specific date, stated that at a specific time it was noted that the specific care had not been completed.

A Registered Practical Nurse (RPN) stated that it was the responsibility of the registered staff to provide the specific care, at the specific times and to document the care.

Director of Nursing (DON) stated that the care as specified in the plan should have been provided to the resident.

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

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of the inspection. This area of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) on June 21, 2016, in a Resident Quality Inspection (RQI) #2016_349590_0016. As a VPC on January 19, 2015, in a RQI # 2015_349590_00003 and as a VPC on June 21, 2016, in a RQI #2016_349590_0016. [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 there is a written plan of care for each resident that sets 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 #2: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) The home's policy titled "Skin and Wound Care Program" last revised September 2015, stated in part: "Registered Staff: Ensure the plan of care is established outlining interventions and treatments; the resident is reassessed weekly and the care plan is revised accordingly. Complete the specific assessment tool weekly."

Review of the clinical record for a specific resident, stated that the resident had altered skin integrity. Director of Nursing stated that any resident with altered skin integrity should be assessed by a registered staff at least weekly, and the assessment documented on the home's specified assessment tool.

A Registered Nurse (RN) stated that when a resident had been assessed as having an area of altered skin integrity, the area would be assessed at minimum, weekly, using the home's specified assessment tool to document the assessment.

Record review for a specific time frame, of the home's specified assessment tool, paper documents was completed for the resident.

Assessments were not completed weekly, for a specific time frame.

Director of Nursing stated that it would be expected that the resident should have received a weekly assessment using the home's specified assessment tool.

B) Review of the clinical record for a specific resident stated the resident had altered skin integrity. Director of Nursing stated that any resident with altered skin integrity should be assessed by a registered staff at least weekly, and the assessment documented on the home's specified assessment tool.

A Registered Nurse (RN) stated that when a resident had been assessed as having an area of altered skin integrity, the area would be assessed at minimum, weekly, using the home's specific assessment tool to document the assessment.

Record review for a specific time frame, of the home's specified assessment tool, paper documents was completed for the resident.

Assessments were not completed weekly, while the resident was in the home, during two specific time frames.

A Registered Nurse (RN) stated that when the resident was assessed it should have been documented on the specified tool and if it was not documented, it likely had not been completed.

Director of Nursing stated that it would be expected that the resident should have received a weekly assessment using the home's specified assessment tool..

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

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of the inspection. This area of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) on January 19, 2015, in a Resident Quality Inspection (RQI) #2015_349590_0003. [s. 50. (2) (b) (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 that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a drug destruction and disposal policy that included that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

Observation of the narcotic drawer of the medication cart for Green Unit on November 8, 2017 at 1215 hours, showed an open ampoule of a controlled substance, in the narcotic drawer, inside a plastic med cup.

A Registered Practical Nurse (RPN) acknowledged that the night shift overlaps the day shift by one hour and in that hour that overlapped, the night shift registered staff had opened the ampoule between 0600 and 0700 hours, removed one dose and had saved it in the narcotic drawer for future use, as the medication was ordered as needed and there

would be additional doses remaining in the ampoule. The RPN stated that there was a specific amount remaining in the ampoule and shared that it was their normal practice to save unused portions of the specific medication in the ampoule for future use and to waste the medication at the end of their shift. The RPN stated they would waste the medication by drawing it up in a syringe and then discarding it down the sink.

The Inspector and Director of Nursing (DON) reviewed policy #9.2 titled Drug Dectruction: Controlled Substances, last revised July 2017, and were unable to locate any reference to the wasting or destruction of injectable controlled substances.

Pharmacy Director of Education and Nursing Communication stated that the pharmacy had policies related to drug destruction however, did not have a policy or procedure related to the destruction of injectable controlled substances when only a partial ampoule was required for a dose.

DON stated that any remaining controlled substance should have been put in for destruction at the time of preparation of the dose. The DON also shared that the home should have policies and procedures that give clear direction to staff related to the destruction of injectable controlled substance when only a partial ampoule is required for a dose.

The licensee has failed to ensure that the home's drug destruction and disposal policy included that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of the inspection. The home has a history of one or more unrelated non-compliance in the last three years. [s. 136. (2) 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 the drug destruction and disposal policy provides for the following:
That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs, to be implemented voluntarily.

Issued on this 17th day of November, 2017

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

Original report signed by the inspector.