Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 5, 2019	2019_777731_0033	019456-19, 020372-19	Complaint

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

KRISTEN MURRAY (731), CHRISTINA LEGOUFFE (730)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 14, 15, 20, 21, 22, 25, and 26, 2019

The following Complaint intake was completed within this inspection:
Complaint IL-70963-LO / Log #019456-19 related to continence care, oral hygiene care, and sufficient staffing

The following Critical Incident intake was completed within this inspection:
Critical Incident System #2823-000008-19 / Log #020372-19 related to continence care, and the prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Resident Care Plan Coordinator (RCPC), a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Substitute Decision Makers (SDMs) and residents.

The inspectors also observed resident rooms and common areas, observed meal service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
2 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	Légende 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear direction to staff and others who provided direct care for the resident.

The Ministry of Long Term Care (MOLTC) received complaint #IL-70963 regarding improper continence care, hygiene care, and staffing concerns related to resident #001. The home submitted Critical Incident System (CIS) report #2823-000008-19 to the MOLTC regarding allegations of neglect and continence care concerns involving resident #001. While in the home, Inspector #731 was stopped by Substitute Decision Maker (SDM) #111, who identified that they had specified concerns for resident #001. SDM #111 stated that they had concerns with a specified symptom of resident #001 and the treatments that were supposed to be provided to the resident. SDM #111 further stated that the staff indicated that on a specified shift of an identified date, the home did not have the treatment prescribed, and instead staff used a treatment not prescribed for the specified area.

In a clinical record review for resident #001, the care plan identified specified interventions for resident #001, which included staff were to apply treatment as prescribed by the physician.

In a review of resident #001’s electronic Treatment Administration Record (eTAR) for a specific month, it included a number of specified treatments for resident #001 to be

provided at specified times/shifts.

In an interview with Registered Nurse (RN) #108, when asked about the orders for resident #001, they stated the one treatment appeared to have been used like an as needed (PRN) treatment, and the other treatment, was provided a specified number of times, daily. When asked if there were any times the treatment would not be applied, RN #108 stated that they would put in a number five into the eTAR. A review of the eTAR identified that the number five indicated "hold medication/see nurses note".

In an interview with Resident Care Plan Coordinator (RCPC) #106, when asked what treatments resident #001 received for specified symptoms, RCPC #106 stated they received a number of identified treatments. When asked if these were regularly scheduled or PRN treatments, RCPC #106 stated that it seemed like the one treatment was to be applied PRN, but was also scheduled regularly. RCPC #106 further stated that the other treatment was to be applied at specific times, daily.

In an interview with Assistant Director of Care (ADOC) #109, when asked if resident #001's specified treatments were daily or PRN treatments, ADOC #109 stated the treatments for one specified area were daily treatments, however the other treatment seemed like it might have been a PRN treatment, and stated that the order was unclear.

The licensee failed to ensure that resident #001's specified treatment provided clear direction to staff on the frequency of use of the treatment. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

On October 7, 2019, the Ministry of Long Term Care (MOLTC) received complaint #IL-70963 regarding improper continence care, hygiene care, and staffing concerns related to resident #001. On October 21, 2019, the home submitted Critical Incident System (CIS) report #2823-000008-19 to the MOLTC regarding allegations of neglect and continence care concerns involving resident #001.

A) In a clinical record review on Point Click Care (PCC) for resident #001, the care plan identified specific interventions for resident #001.

In a review of a report titled "Documentation Survey Report v2", for resident #001 for specified months, it was identified under the intervention/task "ADL – Toilet Use", that no

documentation was completed for an identified number of dates and times.

In separate interviews with Personal Support Worker (PSW) #103 and Registered Nurse (RN) #108, when asked about documentation for toileting, they said the documentation was completed in Point of Care (POC). When asked about the process for completing documentation when a resident is out of the home, they said there still needed to be documentation completed when the resident was not in the home, and it was often documented as “not applicable”. When asked what it meant if a section was blank in the task record, they stated it meant the charting was not completed by staff. When asked about the continence status of resident #001, they stated the resident had specific interventions related to continence.

In an interview with Director of Care (DOC) #101 and Administrator #100, DOC #101 stated the staff documented as soon as possible after the care had occurred. DOC #101 further stated that they understand that documentation may not be completed immediately, and documentation may be completed later on in the shift or at the end of their shift. When asked what the expectation was for completing documentation if a resident was out of the home, DOC #101 stated there was a spot in the documentation to select either resident not available or not applicable when the resident was out of the home. When asked if resident #001 had a specific continence intervention, DOC #101 stated yes. When asked if the resident was toileted on the identified dates and times where blanks were identified in the "Documentation Survey Report v2", DOC #101 stated that the care was completed but the documentation was missed. DOC #101 further stated that there was a mis-communication as to who completed the documentation and for some of the times when the resident was out, the documentation should have been completed as resident not available or not applicable.

In a clinical record review for resident #001, the care plan identified specified interventions related to personal hygiene care.

In a review of a report titled “Documentation Survey Report v2”, for resident #001 for specified months, it was identified under the intervention/task “ADL – Personal Hygiene”, that no documentation was completed for an identified number of dates and shifts.

In a clinical record review for resident #001, the care plan identified specified interventions related to skin integrity.

In a review of a report titled “Documentation Survey Report v2”, for resident #001 for

specified months, it was identified under the intervention/task “MONITOR – Skin Observation”, that no documentation was completed for an identified number of dates and shifts.

In a review of the follow up questions in the POC response history between specified dates for resident #001, it was documented that during the skin observation, specified symptoms were noted on an identified number of dates. Further review of the follow up questions identified that the symptoms were not reported to the registered staff on any of the dates where the symptoms were noted, except for on one occasion.

In an interview with PSW #103, when asked what the process in the home was for completing skin observations, PSW #103 stated they would chart any altered skin integrity issues they saw on a resident, document in POC and report those areas to the nurse. When asked if resident #001 had any areas of altered skin integrity, PSW #103 stated that the resident had specified symptoms on specified areas of their body. PSW further stated that they expected that any time specified symptoms were observed that it would have been reported to the registered staff.

In an interview with RN #108, they stated that the staff would check the resident head to toe during morning and evening care, it was an ongoing process to continue to check the skin, and any changes in skin condition were documented and they would let the registered staff know so they could determine what needed to be addressed. When asked about the process for completing assessments of areas of altered skin integrity, RN #108 stated that registered staff assessed with the prescription when the treatments were due. RN #108 further stated that weekly skin assessments were documented in PCC for specific types of symptoms, but other symptoms would have a progress note completed.

In an interview with Resident Care Plan Coordinator (RCPC) #106 when asked what the expectation is in the home related to monitoring residents’ skin, RCPC #106 stated that usually staff monitor with morning and evening care and with baths. RCPC further stated that it is documented in the POC tasks, and the expectation is that any areas are reported to the registered staff.

In a review of the home’s policy titled “Skin & Wound Care Program”, last reviewed September 2019, stated in part that the purpose of skin care and wound management was to identify residents at risk for skin breakdown, implement strategies to prevent pressure ulcers and minimize infection, and reduce and mitigate the overall incidence of

pressure ulcers. The policy further stated the purpose was to reduce factors that contribute to the development of pressure ulcers, promote an optimal level of resident function, comfort and quality of life, and evaluate resident outcomes. The policy further indicated that PSW and Restorative staff were to report and document any skin concerns or changes to the registered staff for further assessment. (731)

B) During an interview between inspector #731 and Resident Care Plan Coordinator (RCPC) #106, they identified resident #004, as a resident who had specified interventions related to continence care.

A review of resident #004's plan of care in Point Click Care (PCC), identified specific interventions related to continence care.

Review of a report from PCC titled "Documentation Survey Report v2," for specified dates, for resident #004, included documentation each shift of "Activities of Daily Living (ADL)- Toilet Use." There was no documentation on an identified number of dates and shifts for "ADL- Toilet Use".

During an interview with RCPC #106 they said that staff documented care provided to residents in Point of Care (POC) in PCC. They said that typically staff would document toileting every shift, unless POC was set up with specified times. They noted that resident #004 did not have specific times noted in POC for toileting and thought that this was likely because the resident's plan of care included more general, rather than specific times for toileting. They said that currently the only way that they could ensure that toileting was being completed as per the plan of care, for residents with specified times for toileting that were not entered into POC, was if registered staff followed up. They said that the home had recently completed a "Gap Analysis" with their Registered Nurses of Ontario (RNAO) Best Practices Coordinator and they were aware that they needed to improve their documentation of continence care and planned to work on this as part of their annual review of the continence care program in the home.

RCPC #106 said that they were familiar with resident #004. They said that resident #004 had specified interventions related to continence care. The RCPC felt that the home was able to meet the needs of resident #004. After reviewing the documentation for resident #004's continence care for specified dates, they said that it did not meet the expectation of the home, as they expected staff to document on every shift. (730)

C) During an interview between inspector #731 and Resident Care Plan Coordinator

(RCPC) #106, they identified resident #005, as a resident who had specified interventions related to continence care

A review of resident #005's plan of care in Point Click Care (PCC), identified specific interventions related to continence care.

Review of a report from PCC titled "Documentation Survey Report v2," for specified dates, for resident #004, included documentation each shift of "Activities of Daily Living (ADL)- Toilet Use." There was no documentation on an identified number of dates and shifts for "ADL- Toilet Use".

During an interview with Personal Support Worker (PSW) #106, they said that they document continence care for residents in POC. They said that the expectation would be that they would document every time the resident was toileted. They said that they sometimes missed documenting. They said they were familiar with resident #005 and that they were toileted at specified times of the day, by family request. PSW #106 said that they felt that the home was able to meet resident #005's needs related to toileting. After reviewing the documentation for resident #005's continence care for specified dates, they said that it did not meet the expectation of the home, but that they often got busy and didn't have time to document. (730)

In a review of the home's policy titled "Scheduled Toileting", last reviewed September 2019, it stated that "an individual toileting schedule will be provided to each resident who is unable to toilet independently and who has been assessed as having the potential to benefit from a schedule". The policy further indicated that following the staff member assisting the resident to and from the toilet and completing associated tasks, the staff were to document the care on the POC.

D) In a clinical record review for resident #006, in the report titled "Documentation Survey Report v2", it was identified under the intervention/task "ADL – Personal Hygiene", that no documentation was completed for an identified number of dates and shifts.

In an interview with PSW #103, when asked who completed oral hygiene care for residents, PSW #103 stated the PSWs completed the care when doing the morning and evening care. PSW #103 stated it was documented in the POC, but it was a general hygiene category, not specific to oral hygiene care. When asked what it would mean if a section was blank in the task record, PSW #103 stated that would mean the documentation wasn't completed.

In an interview with RN #108, they stated that the PSW completed oral hygiene care with morning and evening care, it was documented in the POC, and they would let the registered staff know if there were any problems with completing the care. RN #108 stated resident #001 had specified interventions related to oral hygiene care.

In an interview with DOC #101 and Administrator #100, DOC #101 stated that oral hygiene care was provided with morning and evening care or as needed or indicated by the care plan if outside the normal routine. DOC #101 stated documentation was completed as part of the overall morning and evening care – grouped within the personal hygiene care task. DOC #101 stated resident #001 had specified interventions related to oral hygiene care. When asked if the resident was provided oral hygiene care on the identified dates and times where blanks were identified in the "Documentation Survey Report v2", DOC #101 stated that the care would have still been completed but the expectation would have been that it was also documented.

In a review of the home’s policy titled “Personal Hygiene – AM & HS care”, last reviewed September 2019, it stated that “Each resident shall receive assistance as needed with her/her personal hygiene needs, every morning and evening and more often as necessary”. The policy further indicated that staff were to complete oral hygiene and insert/remove dentures, as needed, and staff were to document the care provided on the POC.

The licensee has failed to ensure that the provision of the care set out in the plans of care for resident’s #001, #004, #005, and #006 were documented. [s. 6. (9) 1.]

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 the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The Ministry of Long Term Care (MOLTC) received complaint #IL-70963 regarding improper continence care, hygiene care, and staffing concerns related to resident #001. The home submitted Critical Incident System (CIS) report #2823-000008-19 to the MOLTC regarding allegations of neglect and continence care concerns involving resident #001. While in the home, Inspector #731 was stopped by Substitute Decision Maker (SDM) #111, who identified that they had specified concerns for resident #001. SDM #111 stated that they had concerns with a specified symptom on resident #001 and the treatments that were supposed to be provided to the resident. SDM #111 further stated that the staff indicated that on a specified shift of an identified date, the home did not have the treatment prescribed, and instead staff used a treatment not prescribed for the specified area. Inspector #731 brought forward the concern to Administrator #100.

In a clinical record review for resident #001, the care plan identified specific interventions related to treatments.

In a review of resident #001’s electronic Treatment Administration Record (eTAR) for a specific month, it included an identified number of ordered treatments for resident #001.

A) In a clinical record review for resident #001, from a specified date and shift, it was documented in the electronic Treatment Administration Record (eTAR) for resident #001 that the treatment for a specified area was applied as prescribed. There was no documentation to indicate that the treatment was not applied or that the treatment was not available.

In an interview with Administrator #100, they stated that the concern related to not having the treatment for the specified area available and the staff member applying the incorrect treatment to the specified area was followed up with as an internal complaint and was treated as a medication incident.

In an interview with ADOC #109, when asked about the results of the investigation regarding applying the treatment to resident #001 on a specified date, ADOC #109 stated that the registered staff documented that the ordered treatment for the specified area was provided, but it was verified that they had used a different treatment for resident #001 as they didn't have any of the specified treatment in the cart. ADOC #109 further stated that the treatment had come in from pharmacy, but had not yet been delivered to the home area. When asked what the expectation was in the home regarding providing and documenting the treatments, ADOC #109 stated that the staff member should have either asked if the treatment had come in from pharmacy, or documented that there was no treatment product available. ADOC #109 further stated that the staff member did not provide the prescribed treatment to the specified area, and they used the wrong ordered treatment on the area.

B) In a review of resident #001's electronic Treatment Administration Record (eTAR) for a specified month, a specified treatment had no documentation completed for a specified date and shift, and on an identified number of dates and shifts the treatment was documented as number five (Hold/see nurses notes) with explanations indicating that the treatment was not provided.

On a specified date, the documentation in the eTAR indicated that the specified intervention was provided to resident #001 as prescribed on a specific shift, however documentation in the progress notes stated it was not applied.

In an interview with Registered Nurse (RN) # 108, they stated a specified treatment was to be provided an identified number of times each day for resident #001.

In an interview with Resident Care Plan Coordinator (RCPC) #106, they stated resident #001 received a number of specified treatments. RCPC #106 stated that a specified treatment was to be provided an identified number of times each day for resident #001. When asked if there had been any issues with the availability of the treatments, RCPC #106 stated no and that staff knew when their stock was getting low and were able to order more of the treatment in. When asked if there were any times that the specified treatment should not have been applied, RCPC #106 stated that the order said every

day, a specified number of times each day, and it seemed to them that the order indicated it should have been provided a specified number of times each day.

In an interview with ADOC #109, they stated the treatments for a specified area were daily treatments. When asked if there had been any issues with the availability of the treatments, ADOC #109 stated not that they were aware of. When asked if there were any times that the specified treatment should not be applied, ADOC #109 stated that the expectation was that the specified treatment for the specified area should have been applied daily, that it was used as a preventative treatment, and the order does not say not to apply if symptoms are not present to the area.

The licensee failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber when resident #001 was provided ordered medicated treatment for a specified area, and applied to a different specified area. The licensee also failed to ensure that resident #001 was administered the ordered preventative treatment as required. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 20th day of December, 2019

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

Original report signed by the inspector.