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
Nov 16, 2021	2021_886630_0034	016135-21	Critical Incident System

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

AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 1, 2, 3 and 10, 2021.

The following Critical Incident (CI) intake was completed within this inspection:

Log #016135-21 / CI 2823-000006-21 related to an unaccounted for controlled substance.

An Infection Prevention and Control (IPAC) inspection was also completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Activation, the interim Director of Care (DOC), a Registered Practical Nurse (RPN), a Housekeeper, Personal Support Workers (PSWs) and residents.

The inspectors also observed resident rooms, medication storage and common areas, observed meal service, observed IPAC practices within the home, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed COVID-19 Directive #3 and Directive #5 for Long-Term Care Homes and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 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 the drug destruction and disposal policy for controlled substances, that was in place in the home as part of the medication management system, was complied with.

O. Reg. 79/10, s.114 (1) and s.114 (2) requires written policies and procedures for the medication management system to ensure the accurate destruction and disposal of drugs in the home.

O. Reg 79/10 s. 136 (2) requires the drug destruction and disposal policy for controlled substance to include the provision that these are 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.

The observed and reported practice for storing a specific controlled substance was not compliant with the home's policy. This policy directed that a specific controlled substance was to be removed from the active supply by two registered staff after completing the shift count. It also directed that controlled substances removed from the active medication supply were to be stored in a double-locked location away from the active medication supply until destruction. There was no harm to residents related to this medication management practice in the home.

Sources: Medication storage observations; the home's policy related to a specific controlled substance; a resident's administration and disposal record and other clinical records; interviews with the interim Director of Care (DOC) and other staff. [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of a missing controlled substance no later than one business day after the occurrence of the incident.

During a routine destruction of controlled substances, the Pharmacist and two nursing staff identified that there was a missing controlled substance. The home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care (MLTC) over a month after the incident. The interim DOC said they were aware of the reporting requirements and they were not sure why there was a delay in reporting. There was no harm to the residents related to this late reporting.

Sources: A CI report; the home's investigation documentation; an interview with the interim DOC. [s. 107. (3) 3.]

Issued on this 16th day of November, 2021

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

Original report signed by the inspector.