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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 3, 2014	2014_216144_0034	L-000663-14	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

CAROLEE MILLINER (144), NANCY SINCLAIR (537), PATRICIA VENTURA (517)

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 9, 10, 11, 12, 13, 16, 17.

During the course of the inspection, the inspector(s) spoke with spoke with 40+ residents, the President of the Resident Council, three family members, the Administrator, Director of Care, three Registered Nurses, five Registered Practical Nurses, five Personal Service Workers, the Director of Nutritional Services and Director of Activation, the Registered Dietitian and Physiotherapist, two Restorative Care Aides, one Physiotherapy Assistant, one Housekeeping Aide and one Maintenance staff.

During the course of the inspection, the inspector(s) toured all resident home areas, observed dining services, medication rooms, medication administration, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and reviewed one critical incident report, resident clinical records, posting of required information, meeting minutes related to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Food Quality
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 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. a) Resident #784 experienced a fall that resulted in a significant change in their

health status.
b) Prior to the fall, the resident was independent and now requires assistance of staff.
c) A significant change in status assessment was completed and confirmed the resident's physical status had deteriorated.
d) A post fall assessment was not completed. The home's fall policy, revised February 2011, includes that an assessment for risk of falls "will be completed when there is a significant change in a resident's physical condition."
e) Two staff and one management personnel confirmed a fall assessment should have been completed.
f) Head injury routine was not initiated. The home's head injury routine policy revised September 1996, includes that "the Registered Nurse will initiate a Neurological Assessment Record for any resident who suffers a direct blow to the head."
g)Two staff shared their belief the assessment was completed and further confirmed that the neurological assessment record for this resident is not available for the Inspector.
h) The resident was prescribed medication for pain. A pain assessment was not completed to assess the effectiveness of the medication in reducing the resident's pain.
i)The home's policy related to pain management revised February 2012, includes the "Comfort Control Chart is used when a resident complains of increased pain or when a new pain medication has been ordered." The information gathered over seven (7) days on the comfort control chart is then used to complete a pain assessment.
j)Two staff confirmed the comfort control chart and pain assessment were not completed when the new medication was initiated. [s. 8. (1) (a),s. 8. (1) (b)]

2. a) The home' policy, Clinical Pharmacy Services: Medication Disposal - Narcotics, revised October 2010 indicates the following:
Procedure:
#6. On a pre-determined date and time, the consultant pharmacist and registered nursing staff member appointed by the Director of Care remove the narcotic and controlled medications for destruction from the double-locked location designated for narcotic and controlled drugs awaiting disposal. The keys for the designated area are only controlled by one individual in the home, typically by a member of the registered senior management team, most often the Director of Care.
b) A Registered Staff indicated that the key to the double-locked narcotic and controlled medications container is kept on the key ring that is passed shift to shift by the Registered Staff.
c) The Director of Care confirmed that the key to the double-locked location is not

controlled by one individual as per the home's policy but is located on the key ring that is available to all registered staff and passed from shift to shift. [s. 8. (1)]

3. a) During the initial tour of the home June 9, 2014 the Inspector observed fourteen (14)resident room doors with posted contact precaution notices and yellow pouches of supplies.
b) Contact precaution notices were not posted on four (4) other identified resident room doors where yellow pouches of supplies were located.
c) The home's policy titled: "Infection Control Surveillance" last reviewed October, 2006 includes: "A yellow laminated sign stating, "Please see a staff member before entering room" will be placed near the resident's name plate at the entrance of their room to alert volunteers, visitors and staff that isolation precautions have been implemented."
d)The Infection Control Nurse verified that residents in four identified rooms had active infections and required contact precautions. The Nurse further confirmed residents with contact precautions should have a sign posted outside of their room that would indicate to visitors they were to contact a staff member prior to entering the room. [s. 8. (1)]

4. a) The home's Pain Management Policy last reviewed February, 2012 stated: "Distressful behavours will be assessed to determine if the cause is painful stimuli. All residents with indicators of pain will be assessed according to the facility's guidelines for pain management."
b) Review of the clinical record for resident #835 revealed the resident displayed behaviours during care on seven (7) identified dates.
c) A second resident reported resident #835 has displayed behaviours during care at least once weekly.
d) One management staff revealed that resident #835 had a pain assessment on admission and has not had one since.
e) The manager further verified the expectation was that resident #835 receive a pain assessment by a registered staff member when exhibiting indicators of pain during care, such as behaviours.
f) One registered staff confirmed the resident behaviours have been present since admission.[s. 8. (1) (b)]

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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. a) Observation of the bed for resident #835 revealed a fixed bed rail had been attached to the right side of the bed.
b) One manager revealed that resident's bed had not been assessed to minimize the risk to the resident and that no other resident beds in the home had been assessed for resident safety in the last three years.
c) A second manager verified the expectation was that all resident beds were to be assessed for resident safety. [s. 15. (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 the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize the risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. a) Resident #835 requires total assistance of one staff for meals.
b) On June 17, 2014 the resident was served food without a staff member available to provide assistance.
c) One staff arrived to provide assistance to the resident then left the table during the feeding process and returned five (5) minutes later.
d) The staff providing assistance to the resident left the table a second time during the feeding process and did not return.
e) A second staff arrived at the resident's table to provide the assistance required to complete the meal process and left the table for one (1) minute.
f) Two management staff confirmed food should not have been served to the resident in the absence of a staff member and that it is their expectation staff will remain with a resident throughout the entire meal if the resident requires complete assistance to eat and drink [s. 73. (2) (b)]

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 no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #4: 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. a) Resident #789 has a wound.
b) A specific physical intervention is in place to prevent pressure and further skin breakdown of the wound.
c) The resident was observed by Inspector #144 with the physical intervention applied incorrectly.
d) One staff shared their incorrect understanding of the positioning of the physical intervention.
e) Two additional staff shared their appropriate understanding of the positioning of the physical intervention.
f) The Occupational Therapist documented in the resident's clinical record, the correct application of the physical intervention.
g) The intervention is not included in the current written plan of care and there are no formal instructions for staff related to appropriate placement of apparatus. [s. 6. (1) (c)]

2. a) Resident #789 uses a specialized device for pressure reduction.
b) The current written plan of care directs staff to alter the device at specific times.
c) The Occupational Therapist documented in the resident clinical record, the frequency with which the device should be altered.
d) One staff confirmed they alter the device before and after meals.
e) A second staff stated they were not sure how frequently the device should be altered and alters it two to three times during a shift. [s. 6. (1) (c)]

3. a) Resident #784 experienced a fall resulting in a significant change in their health status.
b) Hospital personnel recommended the resident be referred for assessment to two (2) specific services to determine if adaptive equipment was required.
c) The written plan of care identifies a referral will be made to one of the identified services.
d) As of the date of this inspection, the referral identified in (c) above, has not been completed.
e) The employee responsible for facilitating both referrals, confirmed they did not receive a referral for resident #784 for (c) above.
f) Two additional staff confirmed the resident has not been assessed by one of the recommended services.
[s. 6. (7)]

4. a) Resident #859 has bone deformities.
b) One registered staff confirmed Personal Support Workers implement a specific intervention daily to prevent prevent further deformity.
c) On June 16, 2014 at 2:10 pm, Inspector #144 observed the intervention to prevent further deformity was not being used by the resident.
c) The resident confirmed the intervention is implemented most days and that some days, they "don't bother."
d) The registered staff confirmed a second time, that the intervention is to be implemented daily.[s. 6. (7)]

5. a) Review of the written plan of care for one resident revealed staff were to:
- Check the resident's incontinence product before and after meals, every night before bed and on rounds during the night shift.
- Provide assistance transferring the resident on and off the toilet
- Provide assistance to apply and change the incontinence product
- Provide assistance with hygiene and adjust clothing following toileting.

b)The home's policy titled: "Incontinence Products - Perineal & Cleaning and Product Change" last reviewed in August, 2011 stated: "Residents who wear an incontinent product i.e. brief/pad are to be checked every 2-3 hours to see if the brief/pad requires changing".
c) Interview with two staff revealed the resident was not toileted during the morning shift on one identified date and that the resident has not been toileted during morning shift for a long time.
d) The two staff also revealed when morning care is provided to this resident, they apply a new incontinence product and do not check or change the incontinent product during their shift unless they detect an unwanted odor on the resident.
e) One manager verified the expectation was that staff provided care to this resident according to the resident's written plan of care for continence and toileting. [s. 6. (7)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. a) A review of resident clinical records revealed it has been over one year since three (3) identified resident heights have been taken and recorded.
b) The home's policy, Monitoring Resident's Height/Weight, revised January 2009, indicates the following;
Procedure:
#2. Heights are obtained annually thereafter by the Restorative Department and given to the Director of Nutrition Services. Heights are recorded in centimeters.
c) One Registered Nurse confirmed the above procedure should have been followed.
d) The Director of Nutritional Services confirmed during an interview that it is the home's policy and expectation that heights will be recorded annually for all residents. [s. 68. (2) (e) (ii)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. a) Resident #784 was prescribed prn medication for pain in addition to a regularly scheduled analgesic.
b) The prn medication was administered to the resident on four (4) occasions over eleven (11) days.
c) The resident's clinical record does not include documentation related to the effectiveness of the administered prn medications on two occasions during the eleven (11) days.
d) The medication administration record reflects on a third date, the prn medication was administered once with it's effectiveness documented twice.
e) Two registered staff confirmed the resident's record was not current and that effectiveness of the prn medication was not documented twice over eleven (11) days. They further confirmed the medication was administered once on another date during the eleven (11) days and effectiveness documented twice on the same date. [s. 231. (b)]

Issued on this 3rd day of July, 2014

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