**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**
**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Mar 30, Apr 12, Jul 4, 2011 | 2011_027621_0002 | 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**

LAPOINTE-FISHER NURSING HOME
271 METCALFE STREET, GUELPH, ON, N1E-4Y8

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

DEBORA SAVILLE (192)

## Inspection Summary/Résumé de l'inspection

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

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.**

**During the course of the inspection, the inspector(s) reviewed medical records, observed care, observed medication administration, reviewed policy and procedure.**

**The following Inspection Protocols were used in part or in whole during this inspection:**

**Accommodation Services- Housekeeping**

**Accommodation Services- Maintenance**

**Dignity, Choice and Privacy**

**Medications**

**Minimizing of Restraints**

**Personal Support Services**

**Skin and Wound**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Definitions | Définitions |
| --- | --- |
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.) | 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. |
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | 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 subsections:**

**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;**
**(b) the goals the care is intended to achieve; and**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met;**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits sayants :**

1. A specified resident did not have a written plan of care that sets out planned care. The resident was noted to have a wound. The plan of care related to altered skin integrity was not initiated in a timely manner and the severity of the wound had progressed.
2. The plan of care for a specified resident was not reviewed and revised when the resident's care needs changed. The resident was identified as being palliative. Following return from Hospital the notes indicate the resident was to refrain from taking food or fluid orally. Documentation indicates that fluids were given, although the resident refused to swallow. The plan of care for the specified resident indicates the resident is on a regular diet and texture with thin fluids.
A specified resident had been on bedrest since returning from hospital. The plan of care indicates under transferring - resident can weight bear; under mobility - uses walker to and from dining rooms.
There are no interventions related to a turning or positioning schedule. A Registered Practical Nurse identified during interview that palliative residents are to be turned every two hours and as necessary. The plan of care for the specified resident had not been updated to reflect the residents change in condition and end of life care requirements.

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following subsections:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary;**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits sayants :**

1. During observation it is noted that the left side of a specified resident's wheelchair is soiled with dried food. It is noted that there is a check list for wheelchair cleaning to be completed by the night staff. Wheelchairs assigned for a specified night included the wheelchair observed. Signatures are completed on the checklist indicating that chair cleaning had been completed.
2. The wheelchair belonging to a specified resident is noted to be in disrepair. Both arms of the chair have cracked and missing vinyl. The surface is rough and presents a hazard.

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

**Specifically failed to comply with the following subsections:**

**s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:**
**1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.**
**2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.**
**3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.**
**4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)**
**5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.**
**6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).**

**Findings/Faits sayants :**

1. Identified residents were observed with lap top tables on their wheelchairs. Both resident's have instructions in the plan of care for the use of a seat belt. There is no indication on the plan of care for either resident that a table top is to be used, no physician order, no consent from the resident or substitute decision maker was evident on the medical record. Neither resident was able to independently remove the table top from their wheelchair.
2. During observation a specified resident did not have the lap top table removed or position readjusted.
During the observation period the resident remained in the same location. The only interaction with staff was during nourishment when a beverage was offered. The specified resident was transported to the dining room for lunch and there was no position changed upon arrival in the dining room.

***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 ensuring the following requirements are met where a resident is being restrained by a physical device; that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class; that the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose; that the resident is released from the physic, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.**

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**Findings/Faits sayants :**

1. During observation in the dining room it was noted that a specified resident had a significant growth of facial hair. At 1515 on the same day the resident was observed in his room. When asked about the facial hair he indicated that staff had not shaved him recently.
During observation in the dining room a specified resident was noted to have crusty yellow discharge from both eyes. On observation at 1500 hours in her room, crusty yellow discharge was still evident from both eyes.
During observation in the dining room it was noted that several residents had disheveled hair that did not appear to have been combed. Hair was generally noted to be clean for all residents.

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care**

**Specifically failed to comply with the following subsections:**

**s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).**

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**Findings/Faits sayants :**

1. A specified resident was observed in the dining room. It was noted that finger nails were long with dirt under the nails. Review of the bath sheet indicated that the resident received a bath. Interview with the Administrator confirmed that nail care is to be completed during the bath.
A specified resident was observed sitting in an alcove beside the lounge. The resident appears unshaven and finger nails are noted to be long, jagged with dirt under the nails. Review of the bath sheet indicated that the resident had received a bath on the day observed. Confirmed by signature of PSW. Interview with the Administrator confirmed that nail care is to be completed during the bath.
A specified resident was observed in the corridor beside the lounge. The resident was moved to his bedroom and repositioned in a tilt chair. The resident was noted to have long finger nails with dirt noted under the nails. Review of the bath sheet indicated that the resident was bathed within days of this observation. Interview with the Administrator confirmed that nail care is to be completed during the bath.
A specified resident was observed laying on the bed. During discussion with the resident it was noted that his finger nails were long, jagged with dirt under the nails. Review of the bath sheet indicated that the resident was bathed one day previously. Interview with the Administrator confirmed that nail care is to be completed during the bath.
A specified resident was was observed sitting in a wheelchair in the bedroom. The resident expressed concern about a fungal infection on some of the finger nails. The resident's finger nails were noted to be long with dirt under the nails. The surface of the right thumb and 5th digit appeared rough in texture. Review of the bath sheet indicated that the resident was bathed two days prior to observation. Interview with the Administrator confirmed that nail care is to be completed during the bath.
2. The Registered Practical Nurse interviewed indicated that nails are cut weekly as necessary with the bath. The plan of care for a specified resident indicates that nails and hair are to be done on bath day.
It was noted that some residents of the home have long, rough finger nails.
A specified resident was observed in her room at 1500 hours. The resident's finger nails were noted to be long, rough and dirty and the hands were sticky and visibly soiled.

***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 ensuring that each resident of the home receives fingernail care, including the cutting of finger nails, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**
**Specifically failed to comply with the following subsections:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,**
**(i) within 24 hours of the resident's admission,**
**(ii) upon any return of the resident from hospital, and**
**(iii) upon any return of the resident from an absence of greater than 24 hours;**
**(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;**
**(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and**
**(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).**

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**Findings/Faits sayants :**

1. A specified resident did not receive weekly assessments by a member of the registered nursing staff, of a wound that developed. The resident sustained an injury. Review of the progress notes indicates that a small wound was noted at this time no assessment was completed. A plan of care was not initiated in a timely fashion. Documentation related to the wound is noted on specified dates. A review of the progress notes confirms that the wound had worsened.

***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 ensuring that any 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.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining**
**Specifically failed to comply with the following subsections:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:**
**1. Restrained, in any way, for the convenience of the licensee or staff.**
**2. Restrained, in any way, as a disciplinary measure.**
**3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.**
**4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.**
**5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**

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**Findings/Faits sayants :**

1. Residents within the home have been restrained by use of a physical device, other than in accordance with section 31 of the Long-Term Care Homes Act, 2007. A specified resident was observed in the corridor, sitting in a wheel chair with a lap top table in place, . When asked, the resident was not able to remove the lap top table. The use of a lap top table is not included in the resident's plan of care. A specified resident was observed in the lounge with a table top in place. The resident was not able to remove the table top when asked on two occasions. The use of a lap top table is not included in the resident's plan of care.

***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 ensuring that no resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.***

**Issued on this 3rd day of August, 2011**

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