Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Dates of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
February 9, 10, 14, 15, 16, 17, 18, 2011	2011_190_2823_09Feb092402 2011_137_2823_09Feb092256 2011_155_2823_09Feb092109 2011_144_2823_09Feb091800	Annual L-00223

Licensee/Titulaire

LaPointe Fisher Nursing Home Limited, 1934 Dufferin Ave., Wallaceburg, N8A 4M2

Long-Term Care Home/Foyer de soins de longue durée

Fairfield Park, 1934 Dufferin Ave., Wallaceburg,ON N8A 4M2

Name of Inspectors/Nom de l'inspecteurs
Sandra Fysh, #190; Sharon Perry, #155; Carolee Milliner, #144; Marian C. MacDonald, #137

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an Annual inspection.

During the course of the inspection, the inspectors spoke with the Administrator, Director of Care, Assistant Director of Care, Nutrition Manager, Director of Social Services, Education and Environmental Services, RAI Coordinator; Office Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Restorative Care Aide, residents and family members.

During the course of the inspection, the inspectors conducted a tour of all resident home and common areas, observed residents, observed medication administration and lunch meal, reviewed residents' clinical records and resident charges records, reviewed policies and procedures pertaining to the inspection, as well as minutes of meetings related to the inspection.

The following Inspection Protocols were used during this inspection:

- Dining Observation
- Admission Process
- Continence Care and Bowel Management
- Pain
- Infection Prevention and Control
- Resident Charges
- Falls Prevention
- Medication
- Minimizing of Restraining
- Personal Support Services
- Responsive Behaviours
- Family Council
- Resident's Council
- Quality Improvement
- Accommodation Services: Housekeeping
- Accommodation Services: Laundry
- Accommodation Services: Maintenance
- Dignity, Choice and Privacy
- Hospitalization and Death
- Prevention of Abuse and Neglect
- Recreational and Social Activities
- Skin and Wound

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

16 WN
4 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA,2007,S.O.2007,c.8,s.3(1)(1)
Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
(1) Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Findings:
1. One resident on interview stated her preference is to sleep until 8:00 am. The written plan of care identifies resident sleeps until 7:30 am. One Registered Practical Nurse and one Personal Support Worker on interview confirmed the resident is awakened by staff working the midnight shift, dressed and in her wheelchair prior to the day shift commencing at 7:00 am.

Inspector ID #:	#144

WN #2: The Licensee has failed to comply with LTCHA,2007,S.O.2007,c.8,s.3(1)8
Every licensee of a long term care home shall ensure that the following rights of residents are fully respected and promoted:
(8) Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Findings:
1. On February 10, 2011, and February 16, 2011, immediately prior to the lunch meal, a residents' right to privacy was not maintained when a test and medication administration were provided in the corridor.

Inspector ID #:	#144 and #190

WN #3: The Licensee has failed to comply with LTCHA,2007,S.O.2007,c.8,s.6(1)(a)(b) **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.**	
Findings: 1. The written plan of care for resident a resident does not include the planned care for one open area discovered November 18, 2010 and a second open area discovered January 25, 2011. 2. The written plan of care for a resident does not include the planned care related to a treatment and updated diagnoses. 3. The written plan of care for a resident does not include the goals the care is intended to achieve for a treatment. 4. The written plan of care for a resident does not include the goals care is intended to achieve for specific treatments and diagnoses.	
Inspector ID #:	#144

WN #4: The Licensee has failed to comply with LTCHA,2007,S.O.2007,c.8, s.6(8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the plan and have convenient and immediate access to it.	
Findings: 1. Two personal support workers confirmed that they are not aware of the contents of the plan of care in the computer. 2. One Personal Support Worker when interviewed confirmed that the plan of care in the computer is not accessed and therefore is not aware of the contents of the plan.	
Inspector ID #:	#190
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 with ensuring that all staff, including Personal Support Workers's have convenient and immediate access to the resident's plan of care, to be implemented voluntarily.	

WN #5: The Licensee has failed to comply with LTCHA,2007,S.O.2007,c.8,s.6(10)(b) **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,** **(b) the resident's care needs change or care set out in the plan is no longer necessary.**	
Findings: 1. A resident presented with an open skin area on two recent dates. The written plan of care has not been reviewed and revised to include the above open areas.	
Inspector ID #:	#144

WN #6: The Licensee has failed to comply with O.Reg.79/10,s.15(2)(a) **Every licensee of a long-term care home shall ensure that,** **(a) the home, furnishings and equipment are kept clean and sanitary.**	
Findings: 1. Call bells in several bathrooms were noted to be lying on the floor and were soiled. These call bells were string and not made of a product that would facilitate cleaning. 2. Overbed lights in several resident rooms were too short for the resident to reach to turn the light on and in some rooms, a shoelace or ribbon had been tied to the light so the resident could reach it to turn it on. These "ribbons and shoelaces were observed to be soiled and not of a product that could facilitate cleaning. 3. Toilets were observed to have caulking around the bottom of the toilet that was soiled and cracked.	
Inspector ID #:	#190
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 with ensuring that the pullcord for call bells in bathrooms and overbed lights are clean and long enough for residents to reach, to be implemented voluntarily.	

WN #7: The Licensee has failed to comply with LTCHA,2007,S.O.2007,c.8, s.78(2) **Every licensee of a long-term care home shall ensue that,** **(2) The package of information shall include, at a minimum,** **(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;** **(d) an explanation of the duty under section 24 to make mandatory reports**	
Findings: 1. On review of the admission package was not able to locate the home's policy to promote zero tolerance of abuse and neglect of residents. 2. On review of the admission package was not able to locate information regarding an explanation of the duty under section 24 to make mandatory reports. 3. Interview confirmed that this information is not provided in the admission package.	
Inspector ID #:	#155

WN #8: The Licensee has failed to comply with LTCHA,2007,S.O.2007,c.8,s.85(3) **The licensee shall seek the advice of the Resident's Council and the Family Council, if any in developing and carrying out the survey, and in acting on its results.**	
Findings: 1. During interview, it was confirmed the Licensee does not seek the advice of the Resident's Council in developing the survey.	
Inspector ID #:	#144

WN #9: The Licensee has failed to comply with O.Reg.79/10,s.30(2) **The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.**	
Findings: 1. Fluid restrictions have not been re-evaluated each month as ordered by the physician for a resident.	
Inspector ID #:	#144

WN #10: The Licensee has failed to comply with O.Reg.79/10,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.	
Findings: 1. Throughout the inspection, fingernails were observed to be dirty and not trimmed for four identified residents.	
Inspector ID #:	#144 and #137
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 related to fingernail care, to be implemented voluntarily.	

WN #11: The Licensee has failed to comply with O.Reg.79/10,s.41 Every licensee of a long term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.	
Findings: 1. A resident on interview stated she likes to sleep daily until 8:00 am and the staff get her up around 6:00 am. The written plan of care includes directives that resident likes to sleep until 7:30 am. Interviews with a Registered Practical Nurse and a Personal Support Worker confirmed the resident was awakened today by staff working the night shift, was dressed and sitting in her wheelchair when the day shift commenced.	
Inspector ID #:	#144

WN #12: The Licensee has failed to comply with O.Reg.s.50(2)(b)(i)(iii) **(b)(i) 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** **(b)(iii) 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, (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,**
Findings: 1. A resident presented with multiple areas of impaired skin integrity. New impaired skin areas were identified, however a skin assessment has not been completed by registered nursing staff using a clinically appropriate assessment instrument. 2. There is no evidence in the clinical record of a resident that a wound has been assessed by the registered dietitian. One Registered Nurse on interview confirmed an assessment was not completed by the Registered Dietitian.

Inspector ID #:	#144

WN #13: The Licensee has failed to comply with O.Reg.79/10,s.72(3)(b) The licensee shall ensure that all foods and fluids in the food production system are prepared, stored, and served using methods to, (b) prevent adulteration, contamination and food borne illness.
Findings: During a lunch meal staff were observed: 1. Retrieving soda crackers from a plastic storage container with bare hands. They were placed on a tray and then onto the dining room table by hand. 2. Crushing crackers into resident's soup with bare hands. 3. Removing soiled soup bowls and then serving salad to residents, without washing hands in between.

Inspector ID #:	#137

WN #14: The Licensee has failed to comply with O.Reg.79/10,s.73(1)(4)(10) **Every licensee of a long term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:** **4. Monitoring of all resident during meals.** **10. Proper techniques to assist residents with eating, including safe positioning of resident who require assistance.**
Findings: 1. A resident was observed to have meal (drink, sandwich, and cookie) placed on overbed table and no staff present. 2. Staff were observed standing while feeding ice cream to resident. 3. Staff were observed standing while feeding the main entrée to a resident.

4. A resident was observed to not be provided with assistance during breakfast meal and was further observed in bed with bed placed in a semi-fowler position while eating.
5. The MDS RAP and dietary plan of care for a resident identifies the resident has an impaired ability to feed herself, requires assistance & supervision during meals and likes to eat meals in her room. This resident was observed in bed from 9:07 am to 9:20 am eating without assistance & supervision.

Inspector ID #:	#144 and #155

WN #15: The Licensee has failed to comply with O.Reg.79/10,s.134(a)(c)
Every licensee of a long term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.
(c) there is at least quarterly, a documented reassessment of each resident's drug regime.

Findings:
(a):

1. Daily administration of a prn narcotic analgesic to a resident was initiated on a trial basis for pain management. The clinical record does not include monitoring related to the effectiveness of the medication administered on a daily basis.

(c):

1. Medications were observed to be administered to a resident, but a review of the physician's orders identified that the three month medication review was not signed by the physician.
2. Medication orders for two residents did not have a current physician three month medication and treatment review completed.

Inspector ID #:	#144 and #155

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 drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg.79/10,s.231(b)
Every licensee of a long term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

Findings:

1. Daily temperature readings were ordered for a resident, but the clinical record does not include the results of the temperature reading on eight occasions from February 1-17, 2011.

Inspector ID #:	#144

CORRECTED NON-COMPLIANCE Non-respects à Corrigé				
REQUIREMENT EXIGENCE	**TYPE OF ACTION/ORDER**	**ACTION/ ORDER #**	**INSPECTION REPORT #**	**INSPECTOR ID #**
LTCHA,2007,S.O. 2007,c.8,s.6(1)(c)	WN	1	2010-115-2823-01Sep103807	#115
O.Reg79/10,s.53(1)(1)	WN	3	2010-115-2823-01Sep103807	#115

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Kim Delute for Sandra Dyck
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). May 24, 2011