



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

**Rapport d'inspection  
prévues 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

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Division de la responsabilisation et de la performance du  
système de santé  
Direction de l'amélioration de la performance et de la  
conformité

Licensee Copy/Copie du Titulaire  Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
October 27, 2010	2010_129_2358_26Oct155207	Complaint # H-01512

**Licensee/Titulaire**

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(s)**

Phyllis Hiltz-Bontje #129

**Inspection Summary/Sommaire d'inspection**

The purpose of this inspection was to conduct a complaint inspection related to falls and urinary incontinence.

During the course of the inspection, the inspector(s) spoke with: Administrator, Director of Care, registered nursing staff and personal support workers.

During the course of the inspection, the inspector(s): observed the resident, reviewed the clinical record and reviewed the homes policies and procedures related to falls management and continence care.

The following Inspection Protocols were used in part or in whole during this inspection: Continence Care and Bowel Management as well as Falls Prevention.

- There are no findings of Non-Compliance as a result of this inspection.
- Findings of Non-Compliance were found during this inspection. The following action was taken:

[ 4 ] WN



**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. 6(1)c Every licensee of a long-term care home shall 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.

**Findings:**

The licensee has not ensured that the written plan of care provides clear direction to staff providing care with respect to:

- The plan of care for an identified resident indicates a number of risk factors that increase the resident's potential for falls. The resident is identified as a high risk for falls and has fallen 4 times in a two month period. Care directions to staff do not provide interventions with respect to managing the above noted identified issues in order to prevent further falls.
- The plan of care for the resident identifies that the resident is increasing aggressive when care is being provided. The written plan of care does not provide directions to staff providing care with respect to strategies for managing this responsive behavior while providing care specifically related to increased falls and increased episodes of urinary incontinence.
- The plan of care for the resident directs staff to "monitor the resident for signs of needing to void. During an interview with 2 PSW's (Personal Support Worker) they said "we do not know what those signs might be and we just ask the resident if there is a need to void".
- The plan of care indicates that the resident has a behaviour related to voiding. Care directions for staff do not include directions for managing and/or decreasing the episodes of this behavior.
- During an interview with 2 PSW's providing care to this resident they said that the following care directions are unclear (resident requires assistance for toileting and to report a decrease in the ability to toilet self) because the resident uses the toilet independently.
- Physiotherapy staff assessed this resident and indicated the goal of care is to improve strength, mobility and balance. A RPN (Registered Practical Nurse) confirmed that care directions related to the above noted goal have not been provided to all staff providing care and are not located in the document that staff use to identify the care required by the resident.

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**WN #2:** The Licensee has failed to comply with LTCHA, 2007, S.O. 2007 c. 8 s. 6(4)(a) The licensee shall ensure that the staff and others involved in the different aspects of care or the resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

**Findings:**

The Licensee has not ensured that staff and others involved in the care for the identified resident collaborate with each other in the assessment of this resident with respect to falls.

- A falls risk assessment conducted by nursing staff indicates that the resident is at a high risk for falling related to a number of risk factors. An assessment of how these identified risk factors impact on falls for this resident has not been conducted resulting in staff in the nursing department, recreation staff and physiotherapy staff not being aware of the specific care to be provided to the resident based on those risk factors.
- The registered practical nurse providing care to the resident, confirmed that she is unaware of the assessment conducted by physiotherapy staff in relation to reducing falls. She also indicated at this time that she is unaware of the goals of care or the treatment plan established by physiotherapy for this resident related to falls and was unable to locate this information in the resident's clinical record.
- The Administrator and Director of Care confirmed that physiotherapy assessments are in charts as well as in the computer. The Administrator and Director of care were unable to locate this assessment in either location.

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**WN #3:** 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 resident's plan of care and have convenient and immediate access to it.

**Findings:**

The licensee has not ensured that staff providing direct care to the resident has convenient and immediate access to his plan of care.

- The Administrator indicated that the home does not have printed care plans because all staff have access to the computer and access the care plans and directions for care on the computers. When asked, two personal support workers who were providing care to the resident demonstrated that they were unable to log onto the computer and commented "I don't really know what to do with these computers" and "I can't do that either – a lot of us can't".
- The Director of Care confirmed that she is aware that these staff people do not have adequate computer knowledge and skill to access the plan of care for the residents.
- When asked, the registered practical nurse providing care to the resident demonstrated she was unable to access the physiotherapy assessment or care plan for this resident.



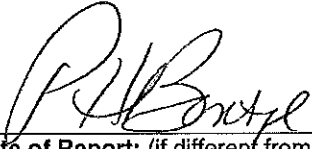
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**WN #4:** The Licensee has failed to comply with LTCHA, 2007, O Reg. 79 10 s. 51(2) (a) Every licensee of a long-term care home shall ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, and assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

**Findings:**  
The Licensee has not ensured that an assessment was conducted and specific interventions developed following the identification of circumstances that were affecting urinary continence and continence care for the resident.

- Personal support staff providing care to the resident indicated that the resident has been demonstrating increasing refusals to have care provided following episodes of incontinence. An assessment has not been conducted of the impact of increasing responsive behaviors being presented by the resident on the staff's ability to provide continence care. There have been no specific interventions identified to guide staff in providing continence care to the resident.
- Care goals related to urinary incontinence established 8 months ago are that the "resident correctly judge the appropriate location to urinate and to be clean/dry and odor free". Increased behaviours being demonstrated by the resident as well as a other factors have not been assessed in relation to the impact these factors and patterns are having on the ability of the resident to attain the care goals established for this resident.

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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.	
			
Title:	Date:	Date of Report: (if different from date(s) of inspection).	
		August 29, 2011	