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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
May 17, 2017	2017_604519_0006	002901-17	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

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

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

SHERRI GROULX (519), JANETM EVANS (659), NUZHAT UDDIN (532), REBECCA DEWITTE (521), SHERRI COOK (633)

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): February 6, 7, 8, 9, 10, 13, 14, 15, 16, 2017

The following intakes were completed within the Resident Quality Inspection (RQI):

#012165-16(2358-000003-16) critical incident related to alleged staff to resident abuse
#034587-16(2358-000009-16), #029112-16(2358-000055-14), #030748-16(2358-000007-16); critical incidents related to falls with injury,
#001478-17(2358-000001-17) critical incident related to fall with hospitalization,
#012144-16(2358-000004-16) critical incident related to hospitalization and change in condition,
#010310-16(2358-000002-16) critical incident related to responsive behaviours

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Resident Assessment Inventory (RAI) Coordinator, the Activation Manager, an Activation staff, a Restorative Aide, the Registered Dietitian, a Physician, the Maintenance Assistant, a Registered Nurse, Registered Practical Nurses, Personal Support Workers, Resident Council representative, Family Council representative, residents and families.

The inspectors toured the home, observed meal service, medication passes, medication storage area and care provided to residents, reviewed medication records and plans of care for specified residents, reviewed policy and procedures, observed recreational programming, staff interaction with residents and general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
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
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **5 VPC(s)**
- **2 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care
Specifically failed to comply with the following:

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. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the electronic record on Point Click Care (PCC) showed a specific resident was assessed as a certain level for falls. The plan of care for the resident showed that the resident was placed on a specific program and that a specific device was being used. On a specified date the resident's plan of care was updated to include monitoring for specific time frames for the resident.

A review of a specific check list was completed, this list described the activities of daily living that had occurred during specified dates and times. The entries had been signed by a Personal Support Worker (PSW).

A review of the progress notes showed that a Registered Practical Nurse (RPN) had found the resident lying on the floor and had an injury to a specific part of their body. The resident's bed had been in the low position and a personal safety device had been present. The resident was transferred to hospital for treatment and returned to the home with a different level of care than when they had left.

The PSW documented statement regarding the incident included time frames that personal care was delivered and the times the PSW was unavailable. The PSW's statement also documented the last time they had visualized the resident.

The Director of Nursing (DON) notes showed that the resident had received personal care at specific times and that a personal safety device was in place. The note stated that the PSW had not monitored the resident during a specific time frame.

During an interview with an RPN they had been administering medications during the time frame that the resident had fallen. The resident was found on the floor and had a specific injury. The bed was in the low position. The RPN called for assistance. The RPN was uncertain if the resident had their personal safety device on or if they had removed it.

During an interview the DON stated that their investigation showed that the staff member had not followed procedures with the home as was the expectation. The DON stated that the PSW had not completed some of the expected tasks. The DON stated that the expectation of the home was that when staff returned from break that they checked to see that all of their residents were safe and this had not been done.

The severity of this issue was determined to be actual harm to the resident, and the scope of this issue was isolated. This area of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) on April 24, 2014, March 4, 2015, and September 2, 2015. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system Instituted or otherwise put in place was complied with.

A review of the clinical record showed that a specific resident was transferred to the hospital and had a change in their status upon return to the home.

A review of the progress notes was completed. The resident had an injury that had been addressed by the staff prior to the resident going to the hospital for treatment. They had noted a change in skin condition on several areas and they were measured.

A review of the Point Click Care (PCC) assessments showed that a Braden Scale was completed for the resident on a specific date. A Head to Toe assessment had been loaded to the resident file on a specified date, but it had not been completed and the status of the assessment indicated that it was “in progress.”

The Director of Nursing (DON) acknowledged that some staff were documenting information related to skin and wounds in the progress notes, but had not documented these assessments under the PCC assessment tab. They stated that the expectation was that staff would document the skin and wound assessment under the assessment tab in PCC.

2. During the observation of medication administration a registered staff member was observed to administer medication to the residents on a specified unit of the home.

During an interview the registered staff member stated that they were in the middle of completing "once daily" medication. The registered staff member explained that they were behind with the medication pass as the Electronic Medication Record (E-MAR) system was fairly new and had "glitches". There were some situations in the home area that were making them take longer to administer drugs to those particular residents.

On a specified date a medication room was observed while a registered staff member completed the documentation on Point Click Care (PCC). The registered staff member was approached by the inspector and noted that they were charting on an outstanding E-MAR and observed that there were fourteen residents in the overdue column for the specific time frame. The inspector inquired about the late documentation and the late administration of medication. The registered staff member explained that they had no time to finish the administration or the charting for the specific time frame of medication.

The home's policy titled, "Administration of Oral Medication", Section M, page 2.6, stated under procedure that Registered Staff were to "initial the medication administration record sheet immediately after administering the medication."

The home's policy titled, "Times of Administration of Medication for first and second floors" Section M Page 2.2, stated "please use the following times for the administration of medication unless specifically ordered otherwise by the physician, allow one hour before and after administration time to give".

During an interview the registered staff member was asked about the expectation and best practice in terms of completing the documentation. The registered staff member stated that the best practice would be to chart immediately after the administration of medication.

During an interview the DON was asked about the E-MAR system. The DON stated that the system was not new and had been in place before a specific year. They stated that there could have been changes made in terms of entering physician's orders into Point Click Care (PCC), but the E-MAR had had no recent changes made to it.

The inspector and the DON reviewed two resident's E-MAR records out of the fourteen residents, for evidence of late and bulk entry. It was discovered that there were no time stamps for late entry in the E-MAR. The DON stated that the "Administration Detail Summary" report would not be typically printed and registered staff would refer to the eMAR as an administration record.

An "Administration Detail Summary" was reviewed for two residents and found several times that were signed for at different times than the expected time frame for the administration of the medication.

The DON stated that the "Administration Detail Summary" reports were reviewed for other residents and that same practice was carried out for them; both the "effective" and "documented" times were entered late by the same registered staff member. The DON stated that it was a practice concern for the registered staff member, as it could potentially place residents at risk or could lead to potential medication errors. The DON said that usually registered staff followed the E-MAR as the source of medication administration and would not print or access the "Administration Detail Summary" report. The DOC stated that this was concerning as the E-MAR only indicated the scheduled times for administration even if the medications were not administered at the scheduled times. The DON stated that the registered staff member was bulk charting and late charting every time they worked. The DON stated that the expectation was that registered staff initial immediately after administering the medication and the expectation was that they had one hour before and one hour post administration time and acknowledged that the "Administration of Medication" policy was not followed by the RPN.

3. During a review of the Critical Incident System report (CIS) showed that a specific resident was sent to the hospital for an assessment of an injury after a fall. They returned to the home with a specified injury.

During a review of the CIS it showed that the resident was sent to the hospital for an injury that was noted to a specific part of their body. According to the CIS, the resident stated that the area was painful. A specified test was done which verified the injury, and the resident returned to the home with a treatment modality in place.

During a review of the documentation for two residents, it was noted that on return from the hospital the registered staff entered a progress note for both residents but did not do a skin assessment on Point Click Care (PCC).

One of the residents had a change in skin integrity that had begun on a specified date. They did not have a weekly skin and wound assessment on PCC for certain dates.

The home's policy titled, "Skin and Wound Care", Section S Page 2:20, dated as revised on May 5, 2015, stated under "Procedure" that Registered staff were to complete a Head to Toe Assessment and Braden Scale (in Point Click Care (PCC)) to identify resident skin integrity, alterations in skin integrity and the risk for altered skin integrity. It stated that these would be completed upon return from hospital. Under number four of "Procedure" it stated that residents with identified altered skin integrity would be reassessed at least weekly using the weekly skin and wound assessment. The weekly skin and wound assessment could be found under the assessment section on Point Click Care.

In an interview with a registered staff member it was stated that skin assessments and full head to toe assessments were done on every resident that returned from hospital. They stated that they were completed on a special assessment tool they had on Point Click Care (PCC).

In an interview with the Director of Nursing (DON) they stated that the skin assessment and head to toe assessment could be done on either the progress notes or on PCC. When the DON was shown the home's policy which outlined the Head to Toe assessment and Braden scale were to be done on PCC they stated that they would need to educate the Registered staff so all assessments were done in the same area using the same tool. The DON stated that even though there were progress notes for some of the weekly wound assessments missed on a specific resident, the assessments were supposed to be recorded on PCC for consistency.

The licensee failed to ensure the home's skin and wound policy was complied with when two specific residents did not have a skin and wound assessment completed on PCC on return from the hospital and one of the resident’s with altered skin integrity did not have weekly skin and wound assessments completed on PCC.

The severity of the issue was determined to a potential for actual harm, and the scope of the issue was a pattern (repeat practice). This non-compliance was previously issued as a Voluntary Plan of Correction (VPC) on July 15, 2014, March 4, 2015, May 13, 2015, and February 29, 2016.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

On a specific date a record review identified a specified resident’s family member had called the home to report staff were allegedly abusing the resident. A review of the progress note identified there would be "follow up".

During an interview with the Director of Nursing (DON) it was stated that the resident had specific medical concerns and these allegations were not reported to the Ministry of Health and Long Term Care (MOHLTC) due to those concerns. When questioned what the home would have in place to manage these allegations the DON stated it was the home's expectation that the staff would follow the policy and protocol of assessing the resident for any evidence of abuse and making the decision to report the alleged abuse based on a "reasonable suspicion that the alleged abuse occurred".

A review of the homes policy titled, "Abuse - Resident /Staff", date of revision March 2014, stated on page 3 bullet 3. "Staff must immediately report every alleged, suspected or witnessed incidents of abuse of a resident by anyone".

During an interview the DON stated that the nurse on duty had not documented a follow up with the resident, and the nurse had not followed the policy and protocol.

The severity of this issue was determined to be potential for actual harm, and the scope of this issue was isolated. This area of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) on March 4, 2015.

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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A Critical Incident System report (CIS) submitted to the Ministry of Health and Long-Term Care (MOHLTC) identified that a resident had fallen from a piece of equipment while it was in use.

A further review of written statements by the staff involved identified that a safety device had been applied incorrectly. Upon recognizing this fault with the applied device, the staff failed to return the resident to the chair in order to correct the issue. A fall occurred that resulted in an injury.

A review of the manufacturer's instructions on February 13, 2017 showed a diagram of the device correctly applied to a body in four progressive stages. A written statement on the instructions stated that for the safety of the patient and carer, before using the device a full risk assessment must be conducted to ensure that the correct device choice, method of positioning in the device and procedure for transfer has been determined for the patient.

During an interview the Director of Nursing (DON) agreed the staff had failed to use the safety device correctly according to the manufacturers' instructions.

The severity of this issue was determined to be actual harm to the resident, the scope of this issue was isolated. This area of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) on March 4, 2015. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of the following with respect to the resident: Health conditions, including allergies, pain, risk of falls and other special needs.

A review of the Critical Incident System report (CIS) noted that a resident had a specific medication ordered for a specific reason. The CIS stated that the resident was found with a change in condition and was sent to the hospital.

A record review of the pain assessment showed that the resident had mild pain and the cause of pain was related to a specific condition.

A record review of the pain assessment showed that the resident had moderate pain less than daily and the cause of pain was related to a different condition.

On a specific date the resident was noted to be sitting and was not able to verbalize their pain.

A record review of the physician's orders showed that the resident was on a specific medication that was to be administered at specified times.

A record review showed that there was no plan of care for pain, or reference to the change in condition which resulted in the resident being transferred to the hospital.

During an interview the Director of Nursing (DON) stated that there was no plan of care for pain for this resident, and stated that the expectation of the home was that there would be a plan of care related to pain for the resident.

The severity of this issue was determined to be a potential for actual harm, the scope of this issue was isolated. This area of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) on September 2, 2015. [s. 26. (3) 10.]

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 plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Health conditions, including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours,including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

During a review of a Critical Incident System report (CIS) a potential incident of resident to resident physical abuse was identified to have had occurred. The CIS report stated that one resident came to the nursing station and said that another resident had attacked them in their room. The resident had sustained altered skin integrity noted on a specific area of their body. The resident had asked the other resident to stop but the resident refused to stop. The resident said that they kicked out to get away then came to the nursing station to inform the nurse.

The DOC was notified regarding the above incident. The DON asked the registered nursing staff why an ambulance was not called and the Registered nursing staff stated that they were not sure which resident caused the injury. The DON asked that staff monitor the resident. The DON asked that registered nursing staff call all POAs and the physician and tell them that the DON would like something done.

The Physician was notified and came into the facility and completed the paperwork for the resident to be transferred to the hospital for medical evaluation. The CIS report showed that the resident was transferred to the hospital and returned to the facility on a different date.

A review of incident reports titled, "Incident by Incident Type", for a specified date range showed that there were several incidents involving the resident and their interactions with other residents, staff, volunteers and families.

The plan of care was reviewed. The plan of care showed that a specialized referral had been completed and it further indicated that certain staff members would assist with the activities for this resident during the day. The plan had specific directions for staff to follow when the resident showed signs of change in their behavior.

During an interview the Director of Nursing (DON) stated that the home had done everything for the resident. DON # 101 indicated that it was very difficult to staff for this situation.

The severity of this issue was determined to be a potential for actual harm, the scope of the issue was isolated. The home had a history of one or more unrelated non-compliance in the last three years. [s. 55. (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 procedures and interventions are developed and implemented: to assist residents and staff who are at risk of harm or who could be harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

An observation of medication administration showed that a registered staff member was administering medication on a specified floor. The RPN was observed preparing medication to be given to an identified resident, they were noted to verify the resident's information and later approached the resident in their room and administered the medication.

In an interview the registered staff member informed the Inspector that they were still in the middle of completing the "once daily medication," and had not started the next pass. The registered staff member explained that they were behind as the Electronic Medication Record (E-MAR) system was fairly new and had "glitches." There was also another issue that was causing the medication to take longer for certain residents.

Policy called Times of Administration of Medication 1st and 2nd floors section M page 2.2 stated that "please use the following times for the administration of medication unless specifically ordered otherwise by physician. Usual medication times - once daily 0830."

The E-MAR was checked for a specific resident and it was noted that once a day medication was ordered for a specific time but it was actually delivered a later time.

In an interview the DOC was asked regarding the E-MAR system. They stated that the system was not new and had been in place before the DOC had started working in the home (couple of years). They stated that there might be changes made to the Point Click Care (PCC) system in terms of entering physician's orders but the E-MAR had no changes made to it currently.

The DOC explained that as per the College of Nurses Medication Standards and the home's policy the registered staff were to administer the medication within one hour of the scheduled time. They stated that the staff had pre and post one hour from the scheduled administration time. The DOC acknowledged that the policy on times of administration was not complied with when the registered staff member administered medication to a specific resident as per orders.

The severity of the issue was determined to be a potential for harm and the scope was isolated. The home had a history of multiple related and unrelated noncompliance. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 144. No licensee of a long-term care home shall discharge a resident from the long-term care home unless permitted or required to do so by this Regulation. O. Reg. 79/10, s. 144.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was discharged from the long-term care home, they did so for the reasons permitted or required by the Regulation.

During a documentation review during Stage two of the Resident Quality Inspection (RQI) it was noted that the resident had been discharged by the home.

Documentation on the resident’s Point Click Care (PCC) notes stated that the resident had been discharged.

Upon review of the Community Care Access Centre (CCAC) notes, it was noted that the Director of Nursing (DON) from the Home reviewed the situation and safety risks with the CCAC case manager and requested approval to not hold the bed for the resident once they were sent to the hospital for a specific medical condition. This was approved by a case manager.

Upon interview with the Specialized Case Manager it was stated that their goal as a team was to keep the residents in their long-term care home and to develop strategies to manage their medical condition.

Upon interview with the resident long-term care home physician # 126 it was stated that they were the physician who sent the resident to the hospital for evaluation. When asked by the inspector if they would have been the person responsible to determine that the resident should be discharged from the home they stated, " I don't recall what happened. I don't know the answer, but I determine it was most likely the nursing director".

Upon interview with the Administrator it was stated that they were not aware of the details surrounding the resident’s discharge from the home as it occurred before they were employed at the home.

The licensee failed to ensure that when a specific resident was discharged from the home they did not do so for the reasons permitted or required by the Regulation.

The severity of this issue was determined to be minimal harm and the scope of this issue was isolated. The home had a history of unrelated non-compliance. [s. 144.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that before discharging a resident under subsection 145 (1) (the resident's requirements for care have changed and as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident of the safety of persons who come into contact with the resident), the licensee would:
- (d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

During Stage two of the Resident Quality Inspection (RQI) it was noted that a specific resident was transferred to the hospital for a medical evaluation. The resident was discharged from the home on a specific date.

Upon interview the Administrator stated that they could not locate a discharge letter associated with the resident’s discharge in the resident's file.

Upon review of the Community Care Access Centre (CCAC) notes, there was no documentation of the receipt of a discharge letter issued from the Home regarding this specific resident’s discharge. This was confirmed by the Administrator when it was stated that in conversation with CCAC they were told that there was not a discharge letter in the resident file.

Upon interview with family member, who also had power of attorney for the specified resident, it was stated that the resident went directly to another facility after leaving the hospital. They stated they had not received a letter that the resident had been discharged.

The licensee failed to ensure that a written notice of discharge was provided to the specific resident substitute decision maker (SDM), and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

The severity of this issue was determined to be minimal harm and the scope of this issue was isolated. The home had a history of unrelated non-compliance. [s. 148. (2)]

Issued on this 17th day of May, 2017

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SHERRI GROULX (519), JANETM EVANS (659), NUZHAT UDDIN (532), REBECCA DEWITTE (521), SHERRI COOK (633)

Inspection No. / No de l'inspection : 2017_604519_0006

Log No. / Registre no: 002901-17

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 17, 2017

Licensee / Titulaire de permis : LAPOINTE-FISHER NURSING HOME, LIMITED
1934 DUFFERIN AVENUE, WALLACEBURG, ON, N8A-4M2

LTC Home / Foyer de SLD : LAPOINTE-FISHER NURSING HOME
271 METCALFE STREET, GUELPH, ON, N1E-4Y8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Dahlia Burt-Gerrans

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To LAPOINTE-FISHER NURSING HOME, LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that all residents in the home that are at a risk for falls are provided the care set out in the plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of the electronic record on Point Click Care (PCC) showed a specific resident was assessed as a certain level for falls. The plan of care for the resident showed that the resident was placed on a specific program and that a specific device was being used. On a specified date the resident's plan of care was updated to include monitoring for specific time frames for the resident.

A review of a specific check list was completed, this list described the activities of daily living that had occurred during specified dates and times. The entries had been signed by a Personal Support Worker (PSW).

A review of the progress notes showed that a Registered Practical Nurse (RPN) had found the resident lying on the floor and had an injury to a specific part of their body. The resident's bed had been in the low position and a personal safety device had been present. The resident was transferred to hospital for treatment and returned to the home with a different level of care than when they had left.

The PSW documented statement regarding the incident included time frames that personal care was delivered and the times the PSW was unavailable. The PSW's statement also documented that the last time they had visualized the resident.

The Director of Nursing (DON) notes showed that the resident had received personal care at specific times and that a personal safety device was in place. The note stated that the PSW had not monitored the resident during a specific time frame.

During an interview with an RPN they had been administering medications during the time frame that the resident had fallen. The resident was found on the floor and had a specific injury. The bed was in the low position. The RPN called for assistance. The RPN was uncertain if the resident had their personal safety device on or if they had removed it.

During an interview the DON stated that their investigation showed that the staff member had not followed procedures with the home as was the expectation. The DON stated that the PSW had not completed some of the expected tasks. The DON stated that the expectation of the home was that when staff returned from break that they checked to see that all of their residents were safe and this had not been done.

The severity of this issue was determined to be actual harm to the resident, and the scope of this issue was isolated. This area of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) on April 24, 2014, March 4, 2015, and September 2, 2015. [s. 6. (7)]

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the Skin and Wound Care, Administration of Oral Medication, and Times of Administration of Medications policies are complied with.

Grounds / Motifs :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A review of the clinical record showed that a specific resident was transferred to the hospital and had a change in their status upon return to the home.

A review of the progress notes was completed. The resident had an injury that had been addressed by the staff prior to the resident going to the hospital for treatment. They had noted a change in skin condition on several areas and they were measured.

A review of the Point Click Care (PCC) assessments showed that a Braden Scale was completed for the resident on a specific date. A Head to Toe assessment had been loaded to the resident file on a specified date, but it had not been completed and the status of the assessment indicated that it was “in progress.”

The Director of Nursing (DON) acknowledged that some staff were documenting information related to skin and wounds in the progress notes, but had not documented these assessments under the PCC assessment tab. They stated that the expectation was that staff would document the skin and wound assessment under the assessment tab in PCC.

2. During the observation of medication administration a registered staff member was observed to administer medication to the residents on a specified unit of the home.

During an interview the registered staff member stated that they were in the middle of completing "once daily" medication. The registered staff member explained that they were behind with the medication pass as the Electronic Medication Record (E-MAR) system was fairly new and had "glitches". There were some situations in the home area that were making them take longer to administer drugs to those particular residents.

On a specified date a medication room was observed while a registered staff member completed the documentation on Point Click Care (PCC). The registered staff member was approached by the inspector and noted that they were charting on an outstanding E-MAR and observed that there were fourteen residents in the overdue column for the specific time frame. The inspector inquired about the late documentation and the late administration of medication. The registered staff member explained that they had no time to finish the administration or the charting for the specific time frame of medication.

The home's policy titled, "Administration of Oral Medication", Section M, page 2.6, stated under procedure that Registered Staff were to "initial the medication administration record sheet immediately after administering the medication."

The home's policy titled, "Times of Administration of Medication for first and second floors" Section M Page 2.2, stated "please use the following times for the administration of medication unless specifically ordered otherwise by the physician, allow one hour before and after administration time to give".

During an interview the registered staff member was asked about the expectation and best practice in terms of completing the documentation. The registered staff member stated that the best practice would be to chart immediately after the administration of medication.

During an interview the DON was asked about the E-MAR system. The DON stated that the system was not new and had been in place before a specific year. They stated that there could have been changes made in terms of entering physician's orders into Point Click Care (PCC), but the E-MAR had had no recent changes made to it.

The inspector and the DON reviewed two resident's E-MAR records out of the fourteen residents, for evidence of late and bulk entry. It was discovered that there were no time stamps for late entry in the E-MAR. The DON stated that the "Administration Detail Summary" report would not be typically printed and registered staff would refer to the eMAR as an administration record.

An "Administration Detail Summary" was reviewed for two residents and found several times that were signed for at different times than the expected time frame for the administration of the medication.

The DON stated that the "Administration Detail Summary" reports were reviewed for other residents and that same practice was carried out for them; both the "effective" and "documented" times were entered late by the same registered staff member. The DON stated that it was a practice concern for the registered staff member, as it could potentially place residents at risk or could lead to potential medication errors. The DON said that usually registered staff followed the E-MAR as the source of medication administration and would not print or access the "Administration Detail Summary" report. The DOC stated that this was concerning as the E-MAR only indicated the scheduled times for administration even if the medications were not administered at the scheduled times. The DON stated that the registered staff member was bulk charting and late charting every time they worked. The DON stated that the expectation was that registered staff initial immediately after administering the medication and the expectation was that they had one hour before and one hour post administration time and acknowledged that the "Administration of Medication" policy was not followed by the RPN.

3. During a review of the Critical Incident System report (CIS) showed that a specific resident was sent to the hospital for an assessment of an injury after a fall. They returned to the home with a specified injury.

During a review of the CIS it showed that the resident was sent to the hospital for an injury that was noted to a specific part of their body. According to the CIS, the resident stated that the area was painful. A specified test was done which verified the injury, and the resident returned to the home with a treatment modality in place.

During a review of the documentation for two residents, it was noted that on return from the hospital the registered staff entered a progress note for both residents but did not do a skin assessment on Point Click Care (PCC).

One of the residents had a change in skin integrity that had begun on a specified date. They did not have a weekly skin and wound assessment on PCC for certain dates.

The home's policy titled, "Skin and Wound Care", Section S Page 2:20, dated as revised on May 5, 2015, stated under "Procedure" that Registered staff were to complete a Head to Toe Assessment and Braden Scale (in Point Click Care (PCC)) to identify resident skin integrity, alterations in skin integrity and the risk for altered skin integrity. It stated that these would be completed upon return from hospital. Under number four of "Procedure" it stated that residents with identified altered skin integrity would be reassessed at least weekly using the weekly skin and wound assessment. The weekly skin and wound assessment could be found under the assessment section on Point Click Care.

In an interview with a registered staff member it was stated that skin assessments and full head to toe assessments were done on every resident that returned from hospital. They stated that they were completed on a special assessment tool they had on Point Click Care (PCC).

In an interview with the Director of Nursing (DON) they stated that the skin assessment and head to toe assessment could be done on either the progress notes or on PCC. When the DON was shown the home's policy which outlined the Head to Toe assessment and Braden scale were to be done on PCC they

stated that they would need to educate the Registered staff so all assessments were done in the same area using the same tool. The DON stated that even though there were progress notes for some of the weekly wound assessments missed on a specific resident, the assessments were supposed to be recorded on PCC for consistency.

The licensee failed to ensure the home's skin and wound policy was complied with when two specific residents did not have a skin and wound assessment completed on PCC on return from the hospital and one of the resident's with altered skin integrity did not have weekly skin and wound assessments completed on PCC.

The severity of the issue was determined to a potential for actual harm, and the scope of the issue was a pattern (repeat practice). This non-compliance was previously issued as a Voluntary Plan of Correction (VPC) on July 15, 2014, March 4, 2015, May 13, 2015, and February 29, 2016.

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of May, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Sherri Groulx

Service Area Office / Bureau régional de services : London Service Area Office