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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 16, 2019	2018_755728_0013	020507-17, 024554-17, 011791-18, 013652-18, 015274-18, 020832-18, 028124-18, 028138-18, 029351-18, 030465-18	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

MARIA MCGILL (728), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 20-23, 26-30, 2018 and December 3-7, 10-12, 14, & 17, 2018.

The following intakes were completed in this complaint inspection:
Log # 020507-17 and Log # 024554-17 related to social work services;
Log # 011791-18, Log # 013652-18, and Log # 028124-18 related to abuse and responsive behaviours;
Log # 015274-18 and Log # 030465-18 related to medications and plan of care;
Log # 020832-18 related to sufficient staffing;
Log # 028138-18 and Log # 029351-18 related to skin and wound.

Inspector, Kristal Pitter (735) attended this inspection during orientation.

PLEASE NOTE: Non-compliance related to LTCHA, 2007, s.6(7), O.Reg. 79/10, s.30(2), s.50(2)(b)(ii), and s. 50(2)(b)(iv), were identified in this inspection and have been issued in Inspection Report 2018_610633_0023, dated January 16, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Certified Enterostomal Therapy Nurse (ET Nurse), Personal Support Workers (PSW), Environmental Services Workers, residents, and family members.

The inspector(s) reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, the home's complaint documentation, relevant family council meeting minutes, and staffing schedules.

Observations were made of staffing, provision of care, staff to resident interactions, resident to resident interactions, and medication administration.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **4 WN(s)**
- **4 VPC(s)**
- **0 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	Légende 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision maker were given the opportunity to participate fully in the development and implementation of the resident's plan of care.

A) A complaint was received related to concerns regarding resident #001 not being provided with a required medication.

A review of resident #001's plan of care documented an order for the identified medication. This order was discontinued from resident #001's plan of care. The resident's plan of care did not document that resident #001 or resident #001's substitute decision maker (SDM) were notified of the change in treatment.

RN #112 said that when an order was changed or discontinued, the resident's SDM would be notified. ADON #105 said that it is the expectation of staff to notify the substitute decision maker when there was a change to the resident's plan of care and said that resident #001's SDM was not notified when the specified medication was discontinued.

B) A review of resident #003's orders documented that an order for an identified medication that was discontinued on a specified date. The order was changed to reflect a different dose of medication. There was no documentation in the resident's plan of care that the SDM was notified of the change in treatment.

ADON #105 said that it was the home's expectation that when an order was changed the SDM would be notified and that in this instance, resident #003's SDM was not notified.

The licensee failed to ensure that the resident and/or the resident's SDM were given the opportunity to participate in resident #001 and resident #003's plan of care when treatments were revised. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: 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:
1. Customary routines. O. Reg. 79/10, s. 26 (3).
2. Cognition ability. O. Reg. 79/10, s. 26 (3).
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).
4. Vision. O. Reg. 79/10, s. 26 (3).
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).
19. Safety risks. O. Reg. 79/10, s. 26 (3).
20. Nausea and vomiting. O. Reg. 79/10, s. 26 (3).
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment with respect to the resident, including the resident's disease diagnoses. s. 26 (3).

The discharge summary provided to the home documented resident #001's current medical history. A review of the resident's plan of care noted that one of the diagnoses was not documented.

RN #112 said that when a resident is admitted, the registered staff were to document the diagnosis available into PointClickCare (PCC). ADON #105 said that the home was made aware of resident #001's diagnoses; however, this diagnosis was not documented in the resident's plan of care.

The licensee failed to ensure that resident #001's plan of care was based on, at a minimum, interdisciplinary assessment of resident #001 disease diagnosis. s. 26 (3). [s. 26. (3)]

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 the plan of care must be based on, at a minimum, interdisciplinary assessment with respect to the resident, including the resident's disease diagnoses, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 62. Every licensee of a long-term care home shall ensure that there is a written description of the social work and social services work provided in the home and that the work meets the residents' needs. O. Reg. 79/10, s. 62.

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written description of the social work and social services work provided in the home and that the work meets the residents' needs.

A complaint was received by the Ministry of Health and Long Term Care (MOHLTC) that indicated that resident #001 was denied access to a social worker when requested.

The home's admission package, included a document that directed families and residents to a counselling program offered by registered social workers. This program was available for persons with dementia and their care partners, family members, and friends.

The home's document of family council minutes directed family council to social work services from the Local Health Integration Network (LHIN) as well as the Behavioural Support Ontario (BSO) program within the home.

The Administrator #100 said that if a resident or family member requested social work services, the home would look to external resources such as the LHIN to provide support as there was no social worker currently employed in the home. They said that a resident should not be declined social work services.

The Administrator #100 said that there was no written description of the social work and social work services provided in the home and no documented evaluation to determine if the services provided met the residents' needs.

The licensee has failed to ensure that there was a written description of the social work and social work services provided in the home and that the work met the residents' needs. [s. 62.]

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 was a written description of the social work and social services work provided in the home and that the work met the residents' needs, to be implemented voluntarily.

WN #4: 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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Resident #001 was not provided with an identified medication as indicated in the physician's orders.

A review of resident #001's orders documented the physician order for a specified medication.

A review of the Medication Administraton Record (MAR) documented that the resident was not provided with the medication at one specified time.

There were no progress notes related to this incident. The Point of Care (POC) system showed the medication to be appearing red.

RN #112 said that because the POC system was red, it meant that the drug was not signed for or given. ADON #105 and DON #106 were unaware of the medication incident. ADON #105 said that because the eMAR was not signed, it was assumed that the medication was not provided to resident #001 as specified by the prescriber.

The licensee failed to ensure that on a specific medication was administered in accordance with the directions for use specified by the prescriber. [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.

Issued on this 4th day of February, 2019

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

Original report signed by the inspector.