Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 27, 2020	2020_777731_0004	002313-20	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

Fairfield Park
1934 Dufferin Avenue WALLACEBURG ON N8A 4M2

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

KRISTEN MURRAY (731), TERRI DALY (115)

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): February 19, 20, 21, and 24, 2020.

The following Complaint intake was completed within this inspection:

Complaint IL-74275-LO / Log #002313-20 related to skin and wound, and continence care

The following Inquiry intakes were also completed during this inspection:

Complaint IL-73464-LO / Log #000312-20
Complaint IL-73946-LO / Log #001517-20
Complaint IL-73949-LO / Log #001519-20
Complaint IL-74483-LO / Log #002794-20

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a Physician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Aides, and residents.

The inspectors also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

The Ministry of Long Term Care (MOLTC) received multiple complaints which included concerns regarding skin and wound, and continence care related to resident #001.

A) In a clinical record review on Point Click Care (PCC) for resident #001, the care plan identified specified sections and interventions related to toileting and continence care.

In a review of the care records for resident #001, for specified dates it was identified under the intervention “ADL – Toilet Use”, that no documentation was completed for an identified number of dates and times.

In an interview with Personal Support Worker (PSW) #110, when asked about the process for completing documentation regarding continence care and toileting, PSW #110 stated documentation was completed in the computer on Point of Care (POC) during their shift once they had time. When asked what the expectation was if a resident was out of the home or refused care, PSW #110 stated that there were sections to select that included “refused care” and if the resident was out of the building they selected “not available” in the documentation. When asked what it meant if a section was blank in the task record for toileting, PSW #110 stated it meant the care wasn’t charted and if the PSW staff were short on time the charting may not have been completed. When asked about the continence status of resident #001, PSW #110 stated the resident had specified interventions related to continence care.

In an interview with Registered Practical Nurse (RPN) #109 when asked the process regarding documentation for continence care and toileting, RPN #109 stated the Personal Support Workers (PSWs) and Health Care Aides (HCAs) document into the tasks and the registered staff can see the information that has been charted under the

tasks section in PCC. When asked what the expectation was for documenting if a resident was out of the home or refused care, RPN #109 stated that if a resident was out of the building there is a tab that says not available and there is an option to indicate they refused. RPN #109 further stated that the registered staff will chart if the resident is on a leave of absence (LOA) or if the staff tell them that the resident refused care.

In an interview with Director of Care (DOC) #102, when asked what the expectation was in the home related to documenting continence care and toileting, DOC #102 stated the expectation was that the PSWs who provided the care document in the flow sheets on POC. DOC #102 further stated that the expectation was that the care is documented as soon as possible after it was provided but indicated it may not be immediately due to the care needs on the unit. When asked what the expectation was for documenting if a resident was out of the home or refused care, DOC #102 stated it was expected that the task be documented according to the current situation and if the resident was out of the building, staff would indicate LOA or “not available”. When asked what it meant if a section of the care record was blank for toileting, DOC #102 stated it could mean that the PSW did not have time to document, although it was expected that documentation be completed. DOC #102 further stated that a blank section does not mean that the care was not provided, but that for some reason the care was not documented.

B) In a clinical record review for resident #002, the care plan identified specified sections and interventions related to toileting and continence care.

In a review of a report titled “Documentation Survey Report v2”, for resident #002, for specified dates, it was identified under the intervention/task “ADL – Toilet Use”, that no documentation was completed on an identified number of shifts and dates.

C) In a clinical record review for resident #003, the care plan identified specified sections and interventions related to toileting and continence care.

In a review of a report titled “Documentation Survey Report v2”, for resident #003, for specified dates, it was identified under the intervention/task “ADL – Toilet Use”, that no documentation was completed on an identified number of shifts and dates.

In a review of the home’s policy titled “Documentation of Care Provided”, last reviewed September 2019, it stated “Care provided to residents will be documented on the electronic record (POC)”. The policy further stated that the staff member caring for the resident will record and sign the required information based upon assessed need or

scheduled tasks as assigned in POC.

The licensee failed to ensure that the provision of the care set out in the plan of care was documented related to toileting for residents #001, #002 and #003. [s. 6. (9) 1.]

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 provision of care set out in the plan of care is documented, to be implemented voluntarily.

Issued on this 27th day of February, 2020

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

Original report signed by the inspector.