Ontario

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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 13, 2016	2016_448155_0004	002310-16	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

SHARON PERRY (155), DOROTHY GINTHER (568), MARIAN MACDONALD (137), NUZHAT UDDIN (532)

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 29, March 1, 2, 3, 7, 8, 9, 10, 11, 14, 15, 2016.

The following inspections were conducted concurrently during this inspection:

Critical Incident inspections: Log # 000343-14 / CI 2358-000049-14; Log # 003741-14 / CI 2358-000056-14; Log # 008622-14 / CI 2358-000063-14; Log # 004012-15 / CI 2358-000007-15; Log # 005270-15 / CI 2358-000008-15; Log # 005638-15 / CI 2358-000009-15; Log # 029471-15 / CI 2358-000022-15; Log # 024324-15 / CI 2358-000016-15; Log # 022727-15 / CI 2358-000015-15; Log # 026761-15 / CI 2358-000019-15; Log # 031193-15 / CI 2358-000024-15; Log # 033976-15 / CI 2358-000025-15.

Complaint inspections: Log # 026222-15 / IL-40632-LO; Log # 027370-15 / IL-40941-LO and IL-40492-LO; Log # 031278-15 / IL-41450-LO; Log # 031456-15 /IL-41518-LO and IL-42286-LO.

Follow-up inspection Log # 032067-15 follow-up inspection of compliance orders # 001 and #002 from inspection number 2015_226192_0050; and compliance orders #001, #002, #003 from inspection 2015_226192_0051.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Director of Operations, Food Service and Nutrition Manager, Activation Manager, Resident Care Coordinator, Maintenance Manager, Maintenance General Helper, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Nurses' Aides, Laundry Aide, Dietary Aide, Resident Council representative, Family Council representative, residents and families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2015_226192_0051	568
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2015_226192_0051	568
O.Reg 79/10 s. 50. (2)	CO #002	2015_226192_0050	532
LTCHA, 2007 S.O. 2007, c.8 s. 6. (2)	CO #003	2015_226192_0051	568
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2015_226192_0050	155

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 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.

On March 10, 2016, at 1230 hours, observations of the medication refrigerators, located in the first and second floor medication room, revealed that there were visible pink stains running down the inside of the refrigerators, food stains on the shelves of the refrigerators and dirt built up inside and outside of the fridge.

Observations were confirmed with Registered Nurse #125, who shared that the nursing staff were responsible for cleaning the refrigerators and informed Inspector #532 that there was a schedule that staff signed when they had completed the cleaning of the refrigerators.

Review of the home's policy named “Care and Cleaning of Fridges in Nursing Department” with review date April 14, 2015, indicated that all refrigerator and freezers were to be cleaned when visibly dirty and monthly, following the monthly schedules in the quality indicator books located at the nursing station.

Record review revealed the schedule for cleaning of the refrigerators was signed off by the registered staff on March 5,2016 for the first floor and on March 4, 2016 for the second floor.

On March 10, 2016, the Director of Care #101 acknowledged that the refrigerators were visibly dirty and needed to be cleaned. They shared that the schedule log was to be signed off by the registered staff after the refrigerators were cleaned but stated that the refrigerators did not appear to be cleaned as per schedule.

The Director of Care #101 confirmed that the policy and procedure related to cleaning of all refrigerators, that were put in place, was not complied with. [s. 8. (1) (b)]

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 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, is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature in the home was maintained at a minimum of 22 degrees Celsius.

During stage one of the Resident Quality Inspection (RQI), a family member expressed a concern that the hallway was cold.

On March 7, 2016 at 1035 hours, a tour of the home revealed cold air coming from wall air vents, to the left of the nurses' desk on both first and second floors.

On March 7 and 8, 2016, Inspector #137 monitored air temperatures on both floors. Near the newer air intake units air temperatures were not at the required minimum temperature of 22 degrees Celsius.

On March 7, 2016, at 1144 hours, the air temperature was 19 Celsius (C) on first floor and confirmed by Personal Support Worker (PSW) # 111.
On March 7, 2016, at 1145 hours, the air temperature was 20 C on second floor and confirmed by Registered Nurse (RN) #104.
On March 7, 2016, resident #002 was seated across from the vent, and requested a blanket, as he/she was cold.

Personal Support Worker (PSW) #110 confirmed there was cold air coming from the air vent.

On March 8, 2016, at 0922 hours, the air temperature was 20 C on first floor and confirmed by maintenance general helper #117.
On March 8, 2016, at 0927 hours , the air temperature was 21 C on second floor and confirmed by laundry aide #116.
On March 8, 2016, resident #021 was observed seated in the hallway across from vent, with a blanket covering resident from neck to feet and resident #002 was observed seated in the hallway across from vent, with a blanket covering resident from neck to waist.

During an interview, with the Maintenance Manager #112, it was revealed that the vents were air make up units, producing fresh air into the hallways and had been adjusted, as family members complained it was too warm.
They further shared that it was difficult to maintain the air temperatures in an old home.

PSW #111, RN #104, Laundry Aide #116 and Maintenance General Helper #117 confirmed the air temperatures were not maintained at a minimum of 22 C.
The Administrator #100 confirmed that the home should be maintained at a minimum temperature of 22C, as per the legislative requirements. [s. 21.]

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 home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services that there were schedules and procedures in place for routine, preventive and remedial maintenance.

Observations, during the initial tour and throughout the Resident Quality Inspection (RQI), revealed identified deficiencies, such as damaged and paint chipped doors, door frames, walls and floors in 22 of 40 (55 per cent) resident rooms.

The routine, preventive and remedial maintenance program schedule did not include painting and identified deficiency repairs.

During interviews, the Maintenance Manager #112 confirmed the identified deficiencies and Administrator #100 acknowledged the home's expectation was that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. [s. 90. (1) (b)]

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 there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Documentation review revealed that when resident #042 was admitted to the home the Behavioural Assessment Tool completed by Community Care Access Centre (CCAC) identified the resident as exhibiting a number of behaviours. The Initial Activation Assessment note identified that resident #042 had a low mood. The resident was withdrawn and there were documented incidents of aggression with care.

Review of resident #042's clinical record revealed that on an identified date, the resident struck a staff member. Staff were able to settle the resident following the incident. Later the same day, resident #042 was witnessed hitting resident #043 in their room. Resident #042 was removed from the room to another area of the home. During the late afternoon, progress notes indicated that a Personal Support Worker (PSW) #127 had reported to a registered staff and another PSW that resident #042 was being verbally aggressive. PSW #127 wanted staff to be aware, as they were going on break. Later, it was identified that staff were called as resident #042 had reportedly struck resident #043.

The Director of Care #101 confirmed that it was the home's expectation that staff would remove resident #042 from an area, should their responsive behaviours pose a risk to other residents in the home.

The Director of Care confirmed that steps were not taken to minimize the risk of altercation between resident #042 and #043. [s. 54. (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

On March 10, 2016 at 1230 hours, observation of the medication refrigerators located in the first and second floor medication room revealed that there was food stored inside the fridge.

In the first floor medication refrigerator, the following items were noted: Tim Horton's smoothie, two packs of cheddar cheese, four yogurts and a jar of peanut butter.

In the second floor medication refrigerator, the following items were noted: two jars of pickles, a jar of jam and three yogurts.

The above observations were confirmed with the Registered Nurse #125, who shared that these food items belonged to the residents and were being stored for the residents.

On March 10, 2016, the Director of Care #101 acknowledged and confirmed that the refrigerators, where drugs were stored, were not used exclusively for drugs and drug-related supplies, as they were also used for resident's food items. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate

locked area within the locked medication cart.

On March 10, 2016 at 1230 hours, observation of the second floor medication room refrigerator revealed that there was a 10 millilitre (ml) vial of Lorazepam 4 milligrams (mg)/ml stored inside the refrigerator.

On March 10, 2016 at 1230 hours, Registered Nurse #125 acknowledged that Lorazepam was a controlled substance and should be stored in a separate, double-locked box and confirmed that it was not.

Review of the policy named "Care and Cleaning of Fridges in Nursing Department" review date April 14, 2015 stated that controlled substances that need refrigeration were to be stored in a two lock secured system in a secured medication room following Ministry Guidelines.

On March 10, 2016, the Director of Care #101 confirmed that the Lorazepam in the second floor medication fridge was not stored in a separate, double-locked box. [s. 129. (1) (b)]

Issued on this 13th day of April, 2016

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

Original report signed by the inspector.