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
Nov 26, 2021	2021_792659_0024	013259-21	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

JANETM EVANS (659), ROMELA VILLASPIR (653)

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 15, 16, 17, 18, 19 and 22, 2021.

The following intake was included in this inspection:
Log #013259-21\Complaint related to medication administration, restraints, skin and wound, infection prevention and control, resident hygiene and continence.

This inspection was completed concurrently with Critical Incident Inspection (CIS) #2021_792659_0023.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Director of Quality Improvement (DQI), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Restorative care/IPAC auditor, Personal Support Workers (PSWs), screeners, a housekeeper and residents.

Observations were completed of IPAC procedures, restraints, staff to resident interactions and general care and cleanliness of the home. Review of documentation was completed, including but not limited to plans of care, progress notes, assessments, relevant policies and procedures

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Minimizing of Restraining
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that restraint by a physical device was included in the plan of care for a resident.

A resident was observed in a wheelchair, restrained with a physical device.

Restraint by a physical device was not included in the resident's plan of care.

Failure to include the restraint by a physical device in the resident's plan of care meant staff were not provided with direction on the provision of care to the resident, potentially increasing the risk of harm to the resident related to the restraint use.

Sources: Observation, care plan, progress notes, and an interview with staff. [s. 31. (1)]

2. The licensee failed to ensure that alternatives to restraining the resident had been tried where appropriate, but had not been effective to address the risk.

The home's policy for physical restraints stated that an Alternative to Restraint/Restraint Assessment must be completed prior to application of a restraint, and updated quarterly.

There was no documentation that interventions in place were ineffective in addressing the risk or that alternatives to restraint were considered prior to the application of a restraint device.

Not ensuring that alternatives to restraining the resident had been tried or considered where appropriate, may have resulted in the resident being inappropriately restrained by staff.

Sources: Observations, review of progress notes, hard copy of resident's chart, care plan and an interview with staff [s. 31. (2) 2.]

3. The licensee has failed to ensure that the plan of care for a resident included an order by the physician or registered nurse in the extended class for the physical device.

A resident's clinical records, did not show evidence of a physician's order or an order by a registered nurse in the extended class, for restraint by a physical device..

Failure to ensure there was an order for the physical device could result in the resident being inappropriately restrained by staff.

Sources: Observations, hard copy of resident chart and electronic documentation on PCC, and an interview with staff. [s. 31. (2) 4.]

4. The licensee has failed to ensure that a resident's plan of care included consent by the Substitute Decision Maker (SDM) for the seatbelt restraint.

The home's policy for restraints said verbal consent was to be obtained by the SDM within 12 hrs of application of a restraint followed by written consent on their next visit to the home. Consent was to be reviewed annually with the SDM.

There was no written or annual consent completed by the SDM related to use of a seat belt.

Failure to obtain consent from the SDM could result in the resident being inappropriately restrained by staff.

Sources: Observations, progress notes, hard copy of resident's chart, home's policy Restraints - section R, last reviewed Mar 4, 2016, interview with staff .

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 if a resident is to be restrained by a physical device, there is an order for the device, there is documented consent from the resident or the SDM for the use of the physical restraint and there is documentation of alternatives that had been considered or tried prior to the implementation of a physical restraint, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: Specifically:

1. The circumstances precipitating the application of the specified device.

5. The person who applied the device and the time of application.

6. All assessment, reassessment and monitoring, including the resident’s response.

7. Every release of the device and all repositioning.

A resident was restrained by a physical device when in their wheelchair.

There was no evidence of an assessment, reassessment or monitoring for the restraint by a physical device for the resident.

There was no evidence as who applied the device and the date and time it was applied, when it was released and when the resident was repositioned.

Failing to complete the documentation above did not result in harm to the resident but limited the home's ability to review and evaluate the resident's ongoing need for a physical restraint.

Sources: Observation, Plan of care, hard copy of resident's chart, progress notes, and an interview with staff. [s. 110. (7)]

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 will document : the circumstances precipitating the application of the physical device, the name of the person who applied the device and the time, all assessment, reassessment and monitoring of the resident when the device is in use, including the resident's response to the device and every release and repositioning of the resident, for each resident who is restrained by a physical device

every use of a physical device to restrain a resident, to be implemented voluntarily.

Issued on this 17th day of December, 2021

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

Original report signed by the inspector.