Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Oct 2, 2019	2019_563670_0036	017207-19	Critical Incident System

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

DEBRA CHURCHER (670)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 30, 2019 and October 1, 2019.

Log# 017207-19 CIS# 2823-000006-19 related to a fall with injury was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Resident Care Plan Manager/Fall Lead, two Registered Practical Nurses and four Personal Support Workers.

During the course of this inspection the Inspector observed the overall cleanliness and general maintenance of the facility, observed staff to resident interactions, observed the provision of care, reviewed relevant clinical records, reviewed relevant internal investigation notes and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. (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.

The Ministry of Long-Term Care received a Critical Incident System report from the home, related to resident #001 experiencing a incident that resulted in a specific medical condition and a significant change in condition.

Review of resident #001's clinical record showed that the resident experienced an incident at a specific time on a specific date. The incident resulted in a specific medical condition.

Resident #001's plan of care had three specific interventions listed.

An observation was completed on a specific date, when the resident was not in the room, it was noted that one of the specified interventions was not in place. During a subsequent observation on a specific date, when the resident was present in the room, the specified intervention was not in place.

During an interview on September 30, 2019, with PSW #105 they stated that they had been assigned to resident #001 for the last week and that during that time frame one of the specified interventions was only in place one time and the two other specified interventions had never been in place.

During an interview on September 30, 2019, with the Resident Care Plan Manager/Fall Lead #101 they stated that the interventions listed in the care plan should have been implemented as described in the care plan.

During an interview on September 30, 2019, the Director of Care #108 acknowledged that the staff had not been providing care as per the plan of care and should have been.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan. [s. 6. (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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 2nd day of October, 2019

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

Original report signed by the inspector.