Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: September 12, 2024
Inspection Number: 2024-1308-0003
Inspection Type: Critical Incident
Licensee: LaPointe-Fisher Nursing Home, Limited
Long Term Care Home and City: Fairfield Park, Wallaceburg

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 4 - 6, 2024

The following intakes were inspected:

- Intake: #00120507/Critical Incident (CI) #2823-000016-24 - related to infection prevention and control
- Intake: #00124252/CI#2823-000020-24 - related to fall prevention and management

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee failed to ensure that an unexpected resident death was reported to the director.

Rational and Summary
No critical incident report was submitted to the director regarding the unexpected death of a resident. The home's staff verified no critical incident report was completed for the death.

Sources: Review of progress notes, Resident Death Record and interview with staff.

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