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: November 7, 2024
Inspection Number: 2024-1308-0004
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 date(s): November 4, 5, 6, 2024

The following intake(s) were inspected:
Intake: #00126277 Critical Incident System report 2823-000023-24 related to a fall with injury.
Intake: #00126560 Critical Incident System report 2823-000026-24 related to responsive behaviors.
Intake: #00127108 Critical Incident System report 2823-000027-24 related to an unexpected death.
Intake: #00127668 Critical Incident System report 2823-000030-24 related to alleged improper care.
Intake: #00128037 Critical Incident System report 2823-000031-24 related to responsive behaviors.

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

Resident Care and Support Services
Infection Prevention and Control

Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan of care.

Rationale and Summary:
Specifically, the resident's care plan directed a specific amount of staff were required to provide care.

The home submitted a Critical Incident System report on a specific date, stating that a Personal Support Worker (PSW) did not follow the plan of care resulting in the resident experiencing a specific condition.

Review of the resident's care plan that was in place at the time of the incident directed that a specific amount of staff were required to perform care.

A progress note was written by a Registered Practical Nurse (RPN) which stated a specific PSW had not followed the residents plan of care resulting in the resident experiencing a specific condition.

During an interview with a PSW who shared that they had been working on the shift when the incident occurred, confirmed that they witnessed another PSW not following the resident's plan of care which resulted in the resident experiencing a specific condition.

Failure to follow the resident's plan of care placed the resident at risk for injury.

Sources: Critical Incident System report, staff interviews, and resident observations and record review.

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