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**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 13, 2019 | 2019_793743_0018 | 016235-19, 016236-19, 016237-19, 016238-19, 017165-19, 018598-19, 018641-19, 020243-19, 020572-19, 020943-19 | Follow up |

### 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

KIYOMI KORNETSKY (743), AMANDA OWEN (738), SHERRI COOK (633)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): November 4-7, 14-15, and 18, 2019.**

**The following intakes were completed in this follow-up inspection:**
**Log #016236-19/ Order Follow Up to CO #002, related to abuse reporting from inspection #2019_800532_007;**
**Log #016237-19/ Order Follow Up to CO #003, related to documentation from inspection #2019_800532_007;**
**Log #016238-19/ Order Follow up to CO #004, related to skin and wound assessments from inspection #2019_800532_007;**
**Log #016235-19/ Order Follow Up to CO #005, related to prevention of abuse from inspection #2019_800532_0007;**
**Log #020943-19/ CI 2358-000027-19 related to alleged resident to resident abuse;**
**Log #018598-19/ IL-70584-CW a complaint related to multiple care issues including bathing, documentation, staff to resident abuse, plan of care and staffing;**
**Log #017165-19/ CI 2358-000014-19 related to alleged staff to resident abuse;**
**Log #018641-19/ CI CI 2358-000018-19 related to resident elopement;**
**Log #020572-19/ CI 2358-000026-19 related to alleged resident to resident abuse;**
**Log #020243-19/ CI 2358-000025-19 related to alleged staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Assistant Director of Nursing (ADOC), the Director of Quality Improvement, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).**

**The inspector(s) reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, the home's documentation related to investigations, falls team meeting notes, relevant employee files and staff schedules.**

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

**Falls Prevention**
**Hospitalization and Change in Condition**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **1 VPC(s)**
- **1 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. 20. (1) | CO #002 | 2019_800532_0007 | 743 |
| O.Reg 79/10 s. 30. (2) | CO #003 | 2019_800532_0007 | 743 |
| O.Reg 79/10 s. 50. (2) | CO #004 | 2019_800532_0007 | 743 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

This inspection was completed as a Follow up to Compliance Order (CO) #005 from inspection #2019_800532_0007 related to the duty to protect residents from abuse and neglect.

As per O. Reg. 79/10 s. 2 (1) physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

The home submitted a Critical Incident System (CIS) to the Ministry of Long Term Care (MLTC), related to an incident of physical abuse by resident #018 towards resident #022.

Registered Nurses (RN) #120 and #107 stated that on the day of the alleged incident, they found resident #022 laying on the floor and the resident stated that resident #018 had caused the incident.

Resident #018's plan of care showed that they had a history of responsive behaviors and previous incidents involving other residents and staff.

ADON #103 stated that resident #018 had a history of responsive behaviors and interventions identified in the resident's plan of care included routine monitoring. This intervention was noted to have been completed just prior to the incident.

The licensee has failed to ensure that resident #022 was protected from abuse by resident #18. [s. 19. (1)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: 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. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

a) A complaint was submitted to the MLTC alleging that Personal Support Worker (PSW) staff were not documenting residents' bowel continence. The complainant alleged that there were multiple shifts without bowel continence documentation; and that this lack of documentation affected the information used by the registered staff to assess if a resident required further interventions to maintain their bowel continence.

According to ADON #103 and PSW #125, PSWS were to document care provided to residents on the residents' flow sheets, and that documentation of the care should have been completed on each shift. PSW #125 also reported that when documenting bowel continence care, they were to indicate whether the resident was continent, or incontinent, the number of times a resident was incontinent as well as a description.

Review of flow sheet documentation was completed for residents #006, #007 and #014; and focused on bowel continence documentation completed over a four day period. Two out of the four days were missing documentation related to bowel continence for residents #006, #007 and #014.

According to ADON #103, lack of bowel continence documentation placed the residents at risk for constipation; as the registered staff utilized the information captured on the residents' flow sheets to determine if the residents required laxatives or suppositories.

b) A Complaint was submitted to the MLTC alleging that residents were not receiving their scheduled showers and baths.

According to ADON #103 and PSW #126, residents were to be bathed or showered twice a week and staff were to document that care was provided on the bath schedule,

as well as on the residents' flow sheets.

Review of the bath schedule and resident care flow sheets was completed; and on three specific dates, there was no documentation that residents #019, #020 and #021 received their scheduled showers.

PSW #126, who was scheduled to work on one of the dates, could not recall if residents #019, #020 and #021, received their scheduled showers that day.

PSW #127 was scheduled to work on two out of the three dates. They reported that they assisted resident #019 with their shower and acknowledged that they did not document the care completed on the resident's flow sheet or bath schedule. PSW #127 was unaware if residents #020 and #021 received their scheduled showers on that date; nor could they recall if residents #019, #020 and #021 received their scheduled showers on the second day they worked.

ADON #103 confirmed that PSW staff did not document the care provided to residents #019, #020 and #021, when there was no documentation about the residents' scheduled showers on three specific dates.

The licensee failed to ensure that the provision of care set out in the plan of care was documented; when staff failed to document bowel continence care provided to residents #006, #007 and #014 and bathing care provided to residents #019, #020 and #021. [s. 6. (9) 1.]

***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 staff document the provision of care as set out in the plan of care, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the nursing staff of the home was on duty and present in the home at all times.

The following is further evidence to support CO #001, issued on September 03, 2019, during Follow Up inspection 2019_800532_0007(A2); to be complied January 30, 2020.

A Complaint was submitted to the MLTC alleging that on a particular shift, there was no RN in the building.

The staffing schedule for a particular date indicated that RN #120 did not work their scheduled shift and there was no documentation that a replacement RN was secured.

RPN #115 who also worked the same shift, confirmed that there was no RN in the building.

When asked if an RN was in the building on a specific date and shift, ADOC #103 said they did not believe so.

The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the nursing staff of the home, was on duty and present in the home at all times. [s. 8. (3)]

**Issued on this 17th day of December, 2019**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | KIYOMI KORNETSKY (743), AMANDA OWEN (738), SHERRI COOK (633) |
| **Inspection No. / No de l'inspection :** | 2019_793743_0018 |
| **Log No. / No de registre :** | 016235-19, 016236-19, 016237-19, 016238-19, 017165-19, 018598-19, 018641-19, 020243-19, 020572-19, 020943-19 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Dec 13, 2019 |
| **Licensee / Titulaire de permis :** | LaPointe-Fisher Nursing Home, Limited<br>1934 Dufferin Avenue, WALLACEBURG, ON, N8A-4M2 |
| **LTC Home / Foyer de SLD :** | LaPointe-Fisher Nursing Home<br>271 Metcalfe Street, GUELPH, ON, N1E-4Y8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Dahlia Burt-Gerrans |

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To LaPointe-Fisher Nursing Home, Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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**Order # / Ordre no :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Linked to Existing Order / Lien vers ordre existant:** 2019_800532_0007, CO #005;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee must be compliant with LTCHA 2007, s.19 (1).

Specifically the licensee must:

a) Ensure that resident #022 and any other resident are protected by abuse from anyone.

a) ensure that resident #018 has responsive behavior interventions in place that mitigate the risk of altercations with resident #022 and any other resident.

b) ensure that the effectiveness of the responsive behavior interventions are being assessed and different approaches considered in the revision of the plan of care.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that residents were protected from abuse by anyone.

This inspection was completed as a Follow up to Compliance Order (CO) #005 from inspection #2019_800532_0007 related to the duty to protect residents from abuse and neglect.

As per O. Reg. 79/10 s. 2 (1) physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

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Registered Nurses (RN) #120 and #107 stated that on the day of the alleged incident, they found resident #022 laying on the floor and the resident stated that resident #018 had caused the incident.

Resident #018's plan of care showed that they had a history of responsive behaviors and previous incidents involving other residents and staff.

ADON #103 stated that resident #018 had a history of responsive behaviors and interventions identified in the resident's plan of care included routine monitoring. This intervention was noted to have been completed just prior to the incident.

The licensee has failed to ensure that resident #022 was protected from abuse by resident #18. [s. 19. (1)]

The scope of this issue was a level 2, isolated. The severity of the issue was determined to be a level 3, actual risk of harm. The home has a level 5 history of non-compliance.
(738)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 31, 2019

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 13th day of December, 2019**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Kiyomi Kornetsky

**Service Area Office /**
**Bureau régional de services :** Central West Service Area Office