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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
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Original Public Report

Report Issue Date June 27, 2022
Inspection Number 2022_1066_0001
Inspection Type

☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
LaPointe-Fisher Nursing Home, Limited
Long-Term Care Home and City
LaPointe-Fisher Nursing Home, Guelph
Lead Inspector
Kim Byberg (729)
Additional Inspector(s)
Robert Spizzirri (705751)
Jessica Bertrand (722374)

Inspector Digital Signature
Kimberly Byberg
Digitally signed by Kimberly Byberg
Date: 2022.07.12 08:57:33 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 9-13, 16-18, 2022.

The following intake(s) were inspected:

The following intake(s) were inspected in this critical incident (CI) inspection:

-Log #008285-22, related to improper care of a resident
-Log #019869-21, and Log #019423-21, related to an allegation of resident abuse

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-Log #018837-21, and Log #019423-21, related to an incident that caused hospitalization and a significant change in health status for a resident.

The following intake(s) were inspected in this complaint inspection:
-Log #020863-21, complaint related to care concerns of a resident

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

- Infection Prevention and Control (IPAC)
- Falls Prevention and Management
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION - REPORTING AND COMPLAINTS

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 107(3.1)(b)

The licensee has failed to ensure that when a resident, suffered an injury and the injury was not yet determined to have resulted in a significant change in health status, a critical incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) within three business days after the occurrence of the incident.

Rationale and Summary

A resident had a fall and sustained an injury that resulted in a significant change in the residents' health. The home submitted a CI report four business days after the incident took place. The Director of Care (DOC) acknowledged the report was not submitted on time.

Sources: CI report, interview with DOC #101.

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[722374]

WRITTEN NOTIFICATION - REPORTING AND COMPLAINTS

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.104(1)(4)(i)

The licensee has failed to ensure that when a CI report was submitted to the MLTC for an allegation of abuse, that the home submitted material in writing to the Director that outlined what immediate actions the home had taken to prevent recurrence of the incident.

Rationale and Summary

The home submitted a CI to the MLTC related to an allegation of abuse of a resident by a staff member.

The DOC acknowledged they did not update the CI with the immediate actions taken to prevent recurrence.

Sources: CI report, interview with DOC #101.

[729]

WRITTEN NOTIFICATION - REPORTING AND COMPLAINTS

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.104(1)(4)(ii)

The licensee has failed to ensure that when a CI report was submitted to the MTLC for an allegation of abuse, that the home submitted material in writing to the Director that outlined the long-term actions planned to correct the situation and prevent recurrence.

Rationale and Summary

The home submitted a CI to the MLTC related to an allegation of abuse of a resident by a staff member**.**

The CI indicated the outcome was yet to be determined. The DOC acknowledged they did not update the CI with the long-term actions taken to correct the situation and prevent recurrence.

Sources: CI report, interview with DOC #101.

[729]

WRITTEN NOTIFICATION - TRANSFERING AND POSITIONING TECHNIQUES

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.40

The licensee has failed to ensure staff used safe transferring devices and techniques when assisting residents.

Rationale and Summary

A) A Personal Support Worker (PSW) assisted a resident to transfer using a mechanical lift. The resident's plan of care required extensive assistance of two staff members for the transfer of the resident. The PSW performed the transfer alone.

The home's Lifts and Transfers Policy stated that two staff members must be present during a transfer using a mechanical lift.

The failure to use safe transferring techniques put the resident at risk of harm.

Sources: The home's investigative notes, Lifts and Transfers Policy (dated June 1, 2021), interview with the resident, PSW and other staff.

[705751]

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B) A PSW transferred a resident from their room to another room in the home using an inappropriate method of transportation. While the PSW was pushing the resident, the equipment used to transfer the resident broke. The resident fell and suffered an injury.

The home's Lifts and Transfers Policy stated that the identified equipment was not to be used as a mode of transportation.

The home's failure to ensure staff used safe transferring techniques and devices resulted in a resident falling and sustaining an injury.

Sources: The home's investigative notes, Lifts and Transfers Policy (dated June 1, 2021), interview with a resident, PSW's and other staff.

[705751]

WRITTEN NOTIFICATION - RESPONSIVE BEHAVIOURS

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s.53 (4)(b)

The licensee has failed to ensure that when a resident was experiencing responsive behaviours, the strategies identified in their plan of care were implemented.

Rationale and Summary

The home submitted a CI report that alleged a PSW applied inappropriate force to a resident while providing care.

The homes Resident Care Co-ordinator (RCC) witnessed the incident and intervened. A skin and wound assessment was performed immediately after the incident, which identified the resident had a new skin impairment.

The Resident had a history of responsive behaviours. Their plan of care included multiple interventions for responsive behaviours that staff were to follow.

The PSW acknowledged they should have followed the residents' plan of care when they exhibited responsive behaviours

When the PSW did not follow the behavioural strategies set out in the residents' plan of care, the resident experienced agitation and a new skin impairment that was identified immediately after the incident.

Sources: Record review of the home's investigation notes, the resident's progress notes, plan of care, eMAR, Physician orders, behavioural education, employee files. Interview with PSW's, DOC #101. Behaviour Management Program Policy Section B, Effective date: January 5, 2015, reviewed June 1, 2021.

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WRITTEN NOTIFICATION - PREVENTION OF ABUSE AND NEGLECT

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s.19(1)

The licensee failed to ensure that a resident was protected from abuse by a PSW.

Rationale and Summary:

Physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain. O. Reg. 79/10 s.2(1)

The home submitted a CI that alleged a PSW was witnessed providing rough care to a resident which resulted in an area of impaired skin integrity for the resident.

The care plan for the resident instructed staff to provide gentle redirection and other strategies to assist the resident when care was provided.

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On a specified date, a PSW entered the resident's room and witnessed another PSW providing care without a second staff present. The PSW was observed applying inappropriate force to the resident. The resident was observed to have an acute injury as a result of the care provided and the incident was immediately reported.

A skin and wound assessment was completed after the incident and identified the resident had a new skin impairment that required immediate treatment and ongoing dressing changes.

When the PSW used physical force to provide care and did not follow the resident's plan of care, the resident sustained impaired skin integrity.

Sources: Review of the residents' skin and wound assessment, progress notes, care plan, MDS assessment, PSW documentation, home's investigation notes, Lapointe-Fisher Abuse policy dated May 6, 2019, employee file, Interview with PSW's, RN and DOC.

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WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2)(b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes (LTCHs) dated April 2022, section 9.1 stated the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include hand hygiene, including, but not limited to, the four moments of hand hygiene (including, before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact.

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The IPAC standard also stated 10.4 (h), the licensee shall ensure the hand hygiene program also includes policies and procedures, as a component of the overall IPAC program, as well as support for residents to perform hand hygiene prior to receiving meals.

The home's hand hygiene policy stated that upon entry to the dining room, staff were to encourage/remind/assist residents to sanitize their hands before eating. The home's hand hygiene policy also indicated staff were to utilize the four moments of hand hygiene which included performing hand hygiene before and after resident/environment contact and after body fluid exposure risk.

A) Observations during the lunch meal service identified five of seven residents were not provided hand hygiene upon entry to the dining room or before eating their meal.

By not encouraging and/or assisting residents with performing hand hygiene before the lunch meal service, there was potential for the spread of infectious microorganisms.

B) During the lunch meal service, a PSW was observed feeding a resident. Throughout the meal, the resident was coughing on their fluids. The PSW, while feeding the resident, served two other residents their desert. The PSW did not complete hand hygiene after feeding one of the residents, or before serving the other residents their dessert.

When the PSW did not perform hand hygiene between assisting residents and after possible exposure to bodily fluids, there was potential for the spread of infectious microorganisms.

Sources: Observations in the dining room, interview with PSW's and DOC #101. Review of policy titled "Hand Hygiene" effective and revised September 23, 2021.

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