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 District
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: September 8, 2023
Inspection Number: 2023-1066-0003
Inspection Type: Critical Incident
Licensee: LaPointe-Fisher Nursing Home, Limited
Long Term Care Home and City: LaPointe-Fisher Nursing Home, Guelph

Lead Inspector	**Inspector Digital Signature**
Mark Molina (000684)	Mark Molina Digitally signed by Mark Molina Date: 2023.09.11 09:38:57 -04'00'

Additional Inspector(s)
Jessica Bertrand (722374) was present at this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28-31, 2023 and September 1, 6, 2023

The following intake(s) were inspected:

- Intake: #00084433 - Related to a fall of a resident resulting in injury

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

Infection Prevention and Control
Pain Management
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 (4) (b)

The Licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborate with each other in the development and implementation of the plan of care, so that the different aspects of care are integrated and are consistent with and complement each other.

Specifically, the physician was not notified of a resident's injury when it became apparent after a fall.

Rationale and Summary
A resident had an unwitnessed fall and at initial assessment, no apparent injuries were noted. Over the next few days, injuries became evident, but the physician was not immediately informed when the injuries became apparent.

As per the home’s Falls Prevention and Management Program policy, the physician was to be notified of a serious injury when an injury became apparent. Director of Nursing (DON) said the physician should have been informed when the injury became apparent.

By not notifying the physician of the injury when it became apparent, treatment of an injury was delayed.

Sources: Resident's clinical records; Falls Prevention and Management Program Policy; interview with DON, and other staff.
[000684]