

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: January 22, 2024	
Inspection Number: 2024-1066-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: LaPointe-Fisher Nursing Home, Limited	
Long Term Care Home and City: LaPointe-Fisher Nursing Home, Guelph	
Lead Inspector Alicia Campbell (741126)	Inspector Digital Signature
Additional Inspector(s) Katherine Adamski (753)	

INSPECTION SUMMARY

<p>The inspection occurred onsite on the following date(s): January 8-12, 15-17, 2024 The inspection occurred offsite on the following date(s): January 11, 2024</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> Intake: #00105482 - Proactive Compliance Inspection

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

- Skin and Wound Prevention and Management
- Resident Care and Support Services
- Medication Management
- Food, Nutrition and Hydration

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

a) The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident regarding the resident's diet order.

Different parts of the residents plan of care indicated different diet orders for the

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

resident. The resident's plan of care was updated to reflect a consistent diet order.

Sources: resident's clinical records; interview with Food Service and Nutrition Manager.

[741126]

b) The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident regarding the resident's toileting status.

A residents care plan showed that they were to receive different levels of assistance for toileting. It was unclear which level of assistance the resident required.

The residents care plan was updated to reflect their current toileting status.

Sources: resident care plan; Interview with staff.

[741126]

Date Remedy Implemented: January 16, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 85 (3) (c)

Posting of information

Required information

s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

The licensee failed to ensure that policy to promote zero tolerance of abuse and neglect of residents was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations.

The Director of Care (DOC) posted the required policy immediately upon being made aware of its' absence.

Sources: observations, interview with the DOC.

[753]

Date Remedy Implemented: January 8, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 20 (d)

Communication and response system

s. 20 Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(d) is available at each bed, toilet, bath and shower location used by residents;

The licensee has failed to ensure that two rooms were equipped with a resident-staff communication and response system that was available at the toilet used by residents.

Three residents occupied these rooms with a shared bathroom. The call bell system in the shared bathroom did not have a string to engage the call bell system.

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Maintenance staff replaced the missing string immediately upon being made aware of the deficiency.

Sources: observations, Maintenance Log Book, interview with staff.

[753]

Date Remedy Implemented: January 8, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 34 (1) 1.

General requirements

s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The licensee failed to ensure that the written description of the home's Fall Prevention and Pain Management programs included protocols for the referral of residents to specialized resources where required.

The home's current Fall Prevention and Pain Management Program included protocols for referring residents to specialized resources, however, the protocol for each program was not written, as required.

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

The Director of Care (DOC) immediately revised the program policies and procedures to include a written description of the protocol for the referral of residents to specialized resources.

Sources: Pain Management Program Policy (Section P 2.0, dated June 2023, revised January 2024), Falls Prevention and Management Program (Section F – 4.0, dated May 2023, revised January 2024), interview with DOC and other staff

[753]

Date Remedy Implemented: January 16, 2024

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee failed to ensure that procedures were implemented for the cleaning and disinfection of the tub in accordance with manufacturer's specifications and

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

using, at a minimum, a low-level disinfectant in accordance with evidence-based practices.

Rationale and Summary

The manufacturer's instructions included in the home's Bath Tub Operation and Disinfection Policy instructed staff to disinfect the tub using a specific procedure.

A Personal Support Worker (PSW) explained their process for disinfecting the tub in between resident use, and this explanation did not reflect the procedure as instructed in policy. The PSW stated that they had not received training on the procedure for disinfecting tubs.

When the manufacturer's specifications for cleaning and disinfecting the tub were not implemented, this increased the risk of spreading infectious disease between residents.

Sources: Bath Tub Operation and Disinfection Policy (Section B – 1.0, revised December 2022), interview with staff.

[753]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(ii) that is secure and locked,

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

The licensee failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

Rationale and Summary

The medication cart, treatment cart, and medication room were observed unlocked on several occasions on both the first and second floor of the home.

Additionally, the treatment cart which contained prescription medications inside and on top was unlocked and left unattended in the hallway on two different occasions.

The Director of Care (DOC) stated that prescription medications should be maintained inside the treatment cart, and that both carts should be secured and locked at all times when unattended by staff.

Sources: observations, interviews with staff.

[753]

WRITTEN NOTIFICATION: Website

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 271 (1) (e)

Website

s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(e) the current report required under subsection 168 (1);

The licensee has failed to ensure that they had a website that included the current

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

report required under subsection 168 (1).

Rationale and Summary

The homes website did not have their quality improvement report posted.

The Administrator confirmed the home did not have their quality improvement report posted on their website.

Not posting the quality improvement report on the home's website was a missed opportunity to ensure timely and consistent dissemination of the information to residents, families, council members and staff of the home.

Sources: the homes website, interview with Administrator.

[741126]