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

Public Report

Report Issue Date: December 4, 2024

Inspection Number: 2024-1066-0004

Inspection Type:
Complaint
Critical Incident

Licensee: LaPointe-Fisher Nursing Home, Limited

Long Term Care Home and City: LaPointe-Fisher Nursing Home, Guelph

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 19 - 22, and 25 - 26, 2024

The following intake(s) were inspected:

- Intake: #00125782 - related to an outbreak.
- Intake: #00131139 - Complainant regarding neglect of resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

The licensee failed to provide a resident with services or assistance required for their health and well-being when resident was exhibiting an acute health status change.

"Neglect" is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary:

A resident had an Advance Directive in place, however staff did not respond in accordance with the Directive.

When the resident verbalized a change in their health status and showed physical signs of an acute change. Staff either did not document timely assessments of the residents or documented incorrect information. in addition, they did not follow the plan of care related to pain management, nor did they notify the physician of the acute health status changes.

The RN advised the SDM of changes in the resident's health status, but recorded information that was not discussed or not in accordance with the SDM's wishes.

Failure to notify the physician of the resident 's acute health status changes prevented a timely fulsome medical examination and potential treatment or

interventions for the acute changes in health status.

Sources: Medical Diagnosis tab**,** Suggestion/Complaint form, dated Oct 30, 2024 related to the resident, plan of care, Progress notes, October 2024, eMAR, Guelph General Hospital MRI results dated 01/11/2024, Advance Directives dated Sept 27,2021, email communications between the DON and physician, interviews with DON, Administrator and staff

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to notify the Director of an allegation of neglect of a resident.

Rationale and Summary:

On a specified date in October 2024, the SDM for a resident met with the DON and RAI Coordinator. They complained that they had been speaking with staff three days earlier and informed the resident was fine.

The next day, during a follow up telephone discussion, with the DON, the SDM said

that an RN had denied the resident had an acute medical incident.

During an in person meeting with the DON and Administrator, the SDM's sister alleged negligence in that the resident was not given immediate treatment.

The Administrator acknowledged they had not notified the Director by submitting a critical incident.

Sources: Suggestion/Complaint form, dated October 30, 2024, interview with DON and Administrator.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to implement protocols issued by the Director with respect to infection prevention and control.

Specifically, they failed to implement quarterly IPAC auditing for all staff to ensure they could perform IPAC skills in accordance with their roles and they failed to

complete assessments on residents which included temperature monitoring.

Rationale and Summary:

A) The home had an outbreak in September 2024.

Resident clinical records showed that staff had not been completing temperature checks for all residents who were symptomatic. as part of the assessment monitoring for residents as recommended by the Director.

The DOC acknowledged that temperatures had not been included as part of the assessment for all residents during the initial days of the Covid-19 outbreak.

B) Auditing records did not show that auditing was being completed for staff from all departments to ensure they could perform IPAC skills in accordance with their roles

The DOC acknowledged quarterly auditing had not been completed in 2024 for all staff in accordance with their roles.

Sources: Line listing for outbreak #2266-2024-00093, The Recommendations for Outbreak Prevention and Control in institutions and Congregate Settings, 2024, Auditing records. interview with DON and ESM.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to immediately report an outbreak to the Director.

Rationale and Summary:

The home notified the Director of the outbreak two days following the outbreak being declared

The DON acknowledged the Director was not immediately notified of the outbreak.

Sources:

CIS 2358-000005-24, Line listing for outbreak #2266-2024-00093, interview with DON/IPAC lead.

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