Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 28, 2014	2014_202165_0007	L-000178-14	Critical Incident System

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

TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 25, 2014

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Director of Care, and Residents.

During the course of the inspection, the inspector(s) reviewed the resident's clinical health record, the home's investigation notes and the home's policy and procedure.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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.) 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. 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 of the long term care home did not ensure that all residents were protected from abuse by anyone.
A) In February 2014, resident #001 began to exhibit identified behaviour towards a Personal Support Worker (PSW). The resident's behaviour continued and the PSW yelled at the resident. The PSW confirmed that their actions were inapproriate for managing this resident's behaviour.
B) Interviews with staff and review of the resident's clinical health record indicated that the resident had a history of identified behaviour. PSW's were able to state strategies for managing the resident's behaviour however, the PSW's written statement and the Director of Care confirmed that these approaches were not used. [s. 19. (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 all residents are protected from abuse by anyone and are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respects the resident's dignity was fully respected and promoted.
A) In February 2014, an identified resident was observed being transported to the shower room with only a blanket covering them. The blanket did not fully cover the resident, exposing their upper shoulders and it was observed to be slipping further down the resident. The PSW confirmed that the resident's clothing was removed prior to transporting the resident. It was confirmed by the Director of Care that using a larger article which fully covered the resident's body would be more dignified. [s. 3. (1) 1.]

WN #3: 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. (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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that there was a written plan of care for each resident that sets planned care for the resident.
A) A review of the Minimum Data Set (MDS) assessment completed in January 2014, indicated that resident #001 exhibited identified behavioural symptoms four to six days during a seven day observation period. Staff interviewed confirmed that the resident often exhibited the identified behavioural symptoms and identified strategies in attempts to manage the behaviour. The Director of Care confirmed that there was no plan of care for the resident that identified the behaviour and strategies to manage the resident's behaviour. [s. 6. (1) (a)]

Issued on this 28th day of February, 2014

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

Tammy Szymanowski