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
Apr 29, 2014	2014_226192_0014	L-000400-14	Follow up

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 24, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care, Food Services Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Environmental Aides, and residents.

During the course of the inspection, the inspector(s) reviewed medical records, policy and procedure, training records, incident reports and the homes incident investigation notes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that care set out in the plan of care was provided to resident #002 as specified in the plan.

Resident #002 sustained a fall while alone in the bathroom in 2013.

The plan of care indicates that the resident was to have "constant supervision and physical assist for safety".

Documentation review and interview with the Director of Care confirmed that the resident was left unattended in the bathroom, attempted to transfer independently and sustained a fall.

The licensee failed to ensure that care was provided as specified in the plan of care for resident #002. [s. 6. (7)]

2. The licensee failed to ensure that care set out in the plan of care was provided to resident #003 as specified in the plan.

Resident #003 sustained a fall while unsupervised in the bathroom in 2013.

The plan of care for resident #003 indicated under toileting that resident #003 was to have one person constant supervision and physical assist for safety.

Record review and interview with the Director of Care indicated that the resident was left alone in the bathroom at the time of the fall.

The licensee failed to ensure that resident #003 was provided care as specified in the plan. [s. 6. (7)]

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 ensuring that care set out in the plan of care is provided as specified in the plan, to be implemented voluntarily.

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THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_226192_0001	192
LTCHA, 2007 S.O. 2007, c.8 s. 20. (2)	CO #002	2014_226192_0001	192
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #003	2014_226192_0001	192
LTCHA, 2007 S.O. 2007, c.8 s. 76. (4)	CO #004	2014_226192_0001	192

Issued on this 29th day of April, 2014

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

Debora Saville (192)