Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: June 26, 2024
Inspection Number: 2024-1308-0002
Inspection Type: Complaint Critical Incident
Licensee: LaPointe-Fisher Nursing Home, Limited
Long Term Care Home and City: Fairfield Park, Wallaceburg

Lead Inspector	**Inspector Digital Signature**
Cassandra Taylor (725)	

Additional Inspector(s)
Morgan Holwell (000823) Jennifer Evans (000816)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29, 30, 2024 and June 3, 4, 2024

The following intake(s) were inspected:

- Complaint Intake: #00113911 - relating to care plan concerns
- Intake: #00112915 -Critical Incident (CI) #2823-000008-24 relating to falls prevention and management.
- Intake: #00114085 -CI #2823-000010-24 N.M. relating to falls prevention and management.
- Intake: #00114545 -CI #2823-000011-24 relating to allegations of neglect, improper/incompetent care.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
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 (7)
Plan of care
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.

The licensee has failed to ensure that two staff members were present when providing care for a resident.

Rationale and Summary
A staff member did not follow the plan of care while providing care to a resident as a result the resident sustained an injury.

During an interview with the Director of Nursing Programs (DONP), it was confirmed that the staff member did not follow the resident's plan of care while providing care.

Sources: Resident's clinical records and an interview with the DONP.
[000823]

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee failed to complete weekly skin and wound assessments for a resident.

Rationale and Summary
A resident was identified as having had altered skin integrity requiring weekly skin and wound assessments. On review of the skin and wound assessments, it was noted that assessments were not completed weekly.

Review of the home’s written wound care program, stated in part; “Reassess residents exhibiting altered skin integrity at least weekly.”.

During an interview the DONP they indicated that the expectation would have been that a skin and wound assessment would have been completed weekly and was

not.

Not completing a weekly skin and wound assessment for the resident placed them at a potential risk of undetected deterioration in their wound and a potential for a delay in treatment changes.

Sources: Resident's medical records, the home's written wound care program and staff interview.
[725]

WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident's pain was not relieved by the initial intervention that the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
A resident was identified as having had pain. During a review of the Electronic Medication Administrator Record (EMAR) for the resident they were identified as using an increased amounts of a Pro-re-nata (PRN) analgesic. The documentation in the EMAR indicated that the PRN medication was frequently documented as ineffective in managing the resident pain and there were no other interventions

documented. Further review of the resident's pain assessments had shown that no assessment were completed when the PRN medication was documented as ineffective.

Review of the Home's written Pain management program, had not provided clear direction that an assessment was required after the initial intervention was ineffective.

During an interview with the DONP they indicated that an assessment should have been completed after the initial intervention was documented as ineffective and was not.

Not completing a pain assessment after the initial intervention did not relieve the resident's pain, placed the resident at risk of unmanaged pain and decreased quality of life.

Sources: Resident's medical records, the home's pain management program and staff interview.
[725]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection

(2).

The licensee failed to ensure that symptoms indicating the presences of infection were monitored every shift for a resident.

Rationale and Summary
A resident was diagnosed with an infection, and received a treatment plan.

During the review of the progress notes infection monitoring was not completed every shift during the course of the treatment for the infection.

The DONP indicated that infection monitoring should have been completed every shift and was not.

Not monitoring for infection symptoms every shift could potentially delay detection of worsening symptoms and delay treatment for the resident.

Sources: Resident's medical records and staff interview.
[725]

WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,

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i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

The licensee failed to ensure that the response provided to a person who made a complaint included, the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary
A complaint Critical Incident (CI) was submitted to the Ministry of Long-Term Care (MLTC), which outlined allegations of neglect and care plan concerns. The Administrator had sent a follow-up response in writing to the complainant which did not include the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

Review of the home's policy for complaints did not provide for direction to include the contact information.

During an interview with the Administrator they confirmed the contact information for the MLTC and Patient ombudsman was not included in the response letter and should have been.

Not including the contact information for the MLTC and patient ombudsman posed no risk to the resident.

Sources: CI report, complaint response letter and staff interview.
[725]

WRITTEN NOTIFICATION: Additional requirements, s. 26 of the Act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 109 (1)
Additional requirements, s. 26 of the Act
s. 109 (1) A complaint that a licensee is required to immediately forward to the Director under clause 26 (1) (c) of the Act is a complaint that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

The licensee failed to immediately forward a complaint to the Director that alleged harm or risk of harm to a resident.

Rationale and Summary
A complaint letter was submitted to the LTCH, which outlined concerns relating to allegations of neglect and care plan concerns for a resident. A CI was not submitted to the MLTC until eight days later.

During an interview with the Administrator, they indicated allegations of abuse or neglect should be forwarded immediately to the Director and were not.

Not reporting the allegations of neglect immediately to the director posed minimal risk to the resident.

Sources: CI report and staff interview.
[725]