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

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Public Report

Report Issue Date: April 17, 2025

Inspection Number: 2025-1308-0002

Inspection Type:
Proactive Compliance Inspection

Licensee: LaPointe-Fisher Nursing Home, Limited

Long Term Care Home and City: Fairfield Park, Wallaceburg

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 7-16, 2025

The following intakes were inspected:

- Intake: #00143994 - Proactive Compliance Inspection - 2025

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Residents' and Family Councils
Food, Nutrition and Hydration
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain 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. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the home was a safe and secure environment for its residents when an exterior door sill was identified as a potential tripping hazard.

During an interview, Administrator #101 agreed that the door could pose a tripping hazard. Administrator #101 explained that staff are present to assist residents in and out of the door, and that no incidents had occurred.

On April 15, 2025, Maintenance Manager #122 provided a quote for a new door threshold that will be purchased and installed once it has been custom manufactured in the next week.

Date Remedy Implemented: April 15, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that its residents were safe from risk of burns related to an unsecured gas fireplace. On April 10, 2025 it was noted that a gas fireplace accessible to residents in a lounge was too hot to touch without burning skin. The unit was immediately deactivated. On April 15, 2025 the home provided proof that a custom screen to create a barrier preventing residents from pressing their hands to the glass had been ordered.

Sources: April 10, 2025 observation, custom screen receipt and confirmation email from installer, interview with Maintenance Manager #122.

Date Remedy Implemented: April 15, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that the care plan of resident #007 was updated when the resident's needs changed. On April 11, 2025, the resident's care plan was updated to reflect their most up-to-date needs and interventions required.

Sources: April 8, 2025 observation, resident #007's care plan, interviews with Staff #108 and Staff #115.

Date Remedy Implemented: April 11, 2025

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that the soap available in several resident washrooms was used as per manufacturer specifications. On April 8, 2025, it was observed that several resident washrooms had expired soap product.

The product was replaced on April 10, 2025.

Sources: Observations and interview with IPAC lead #110.

Date Remedy Implemented: April 10, 2025

WRITTEN NOTIFICATION: Powers of Residents' Council - Duty to respond

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or

recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

Upon the Residents' Council advising the licensee of concerns related to the activity room lights and the green dining room windows, the licensee failed to respond in writing to the Residents' Council within 10 days of receiving the advice.

A Residents' Council member identified concerns during their March 15, 2024 meeting. It was identified that the home did not provide written responses to the Residents' Council.

Source: Record review of Residents' Council minutes and the 2024 complaints folder; Interviews with staff and residents.

WRITTEN NOTIFICATION: Maintenance Services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee failed to ensure that there were procedures in place for remedial maintenance when it was identified that the activity room lights went out when the accessibility button for the door to the main entrance of the home was activated.

The Residents' Council identified the issue in their March 2024 meeting and it was documented on the March 2025 minutes as "ongoing". Maintenance Manager #122, acknowledged the concern during an interview and stated that they had not done their due diligence in fixing the issue.

Sources: Observations of the activity room; record review of Residents' Council minutes; interviews with residents and staff members in the home.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 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 has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, the licensee did not ensure that additional precautions were followed when a PSW failed to don personal protective equipment (PPE) prior to entering a resident's environment who required contact precautions.

Additional Requirement 9.1 under the IPAC Standard directs the licensee to ensure that Additional Precautions are followed in the IPAC program. At minimum, section 9.1 (f), for minimum additional precautions shall include appropriate application of PPE. As per the home's policy, when a resident is on contact precautions, PPE including gloves and gown are to be used while making contact with resident and/or items in their environment.

Sources: Observations, interview with staff and review of home's policy.

WRITTEN NOTIFICATION: Quality

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2)
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
1. The name and position of the designated lead for the continuous quality improvement initiative.
2. A written description of the home's priority areas for quality improvement, objectives, policies, procedures and protocols for the continuous quality improvement initiative for the next fiscal year.
3. A written description of the process used to identify the home's priority areas for quality improvement for the next fiscal year and how the home's priority areas for quality improvement for the next fiscal year are based on the recommendations of the home's continuous quality improvement committee.
4. A written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement in the next fiscal year.
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their Continuous Quality Improvement (CQI) initiative report met each of the requirements of Ontario Regulation (O. Reg), s. 168 (2).

During a record review, the Quality Improvement plans posted to the home's website for the 2025/2026 fiscal year did not fulfill the requirements of O. Reg s. 168 (2). In an interview, the Quality Improvement (QI) Lead #101 was unable to clearly demonstrate how the report posted on the home's website met each requirement under O. Reg s. 168 (2).

Sources: Fairfield Park QIP Progress Report 2024/2025, Fairfield Park QIP Narrative 2025/2026, Fairfield Park QIP Work plan 2025/2026. Interview with the QI Lead.