Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 21, 2020 | 2020_760758_0007 | 009601-20, 011148-20 | 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

DANIELA LUPU (758), SHERRI COOK (633)

## 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): July 2-3, 6-10, and 13, 2020.**

**The following intakes were completed in this Critical Incident System Inspection:**

**Log #009601-20, related to alleged staff to resident abuse, and**

**Log #011148-20, related to fall with significant change in condition**

**PLEASE NOTE: This Critical Incident System Inspection was completed concurrently with complaint inspection #2020_760758_0008 (Log #009601-20 and Log #011148-20).**

**During the course of the inspection, the inspector(s) spoke with the residents, the Administrator, the Director of Nursing (DON), the Director of Quality Improvement (DQI), the Business Manager, the Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Resident Assistant (RA), volunteers and volunteers' supervisor.**

**The inspector(s) reviewed clinical records, plans of care for relevant residents, pertinent policies and procedures, the home's investigative records, relevant training records, and observed resident and staff interactions.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where the Regulation required the licensee of a long term care to have, institute or otherwise put in place any strategy, the strategy was complied with. In accordance with O. Reg. 79/10, s.48 (1)1 and in reference to O. Reg. 79/10, s.49 (1), the licensee was required to have a fall prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the home's Head Injury Routine (HIR) strategy within their falls policy titled “Falls Prevention and Management Program”, effective date April 1, 2019, that required the registered staff to conduct head injury routines at specified time intervals as required.

A. Critical Incident (CI) was submitted to the Ministry of Long Term Care (MLTC) related to resident #002’s unwitnessed fall and head injury on an identified date, for which they were transferred to the hospital.

Resident #002 returned from the hospital the same day and a Head Injury Routine (HIR) was initiated upon their return. The HIR was incomplete for seven specified time intervals.

Registered Practical Nurse (RPN) #120 and Registered Nurse (RN) #109 said that the HIR should have been fully completed. RN #109 stated that there was no other documentation for the incomplete entries.

Director of Nursing (DON) #103 said that staff were expected to complete the head injury routine in its entirety unless the resident refused the vital signs checks or other assessments.

B. Resident #003's clinical records documented that on an identified date, the resident sustained a head injury after a fall and the HIR was initiated. The resident was transferred to the hospital on the same day.

Resident #003's progress notes documented that the resident returned from the hospital the next day, and the HIR was to be continued. The HIR was reviewed and was missing assessments for three specified time intervals.

Resident #003 sustained another fall the next day and a new HIR was initiated. The new HIR was incomplete for six specified time intervals.

RN #109 confirmed the incomplete and missing records and stated that there was no other documentation for those assessments. They said that the assessments should have been fully completed.

C. Resident #004's clinical records documented that the resident had an unwitnessed fall on an identified date and the HIR was initiated.

The HIR was incomplete for three time intervals and was missing assessments for one specified time interval.

RN #109 and DON #102 confirmed that there were incomplete and missing assessments on the HIR form. RN #109 said that there was no other documentation for the incomplete or missing assessments.

The licensee has failed to ensure that where the Act and Regulation required the licensee of a long term care home to have a strategy for falls prevention and management for monitoring of the residents, the strategy for head injury routine was complied with for residents #002, #003, and #004. [s. 8. (1) (a),s. 8. (1) (b)]

***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 where the Act and Regulation required the licensee of a long term care home to have a strategy for falls prevention and management for monitoring of the residents, the strategy for head injury routine is complied with, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (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:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**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. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to a resident was immediately reported to the Director with the suspicion and the information upon it was based.

A CI report was submitted to MLTC on an identified date related to an alleged abuse of resident #001 which occurred two days earlier.

The incident was not reported until two days later by volunteer #112's supervisor.

According to DON #102, the suspicion of abuse should have been reported immediately.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of  a resident occurred, immediately reported to the Director the suspicion and the information upon which it was based, when volunteer #112 did not report immediately the incident of alleged abuse of resident #001. [s. 24. (1)]

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**WN #3:  The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

**Specifically failed to comply with the following:**

**s. 49. (2)  Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.  O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident has fallen a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CI was submitted to the MLTC indicating that resident #002 had an unwitnessed fall and sustained an injury for which they were transferred to the hospital. Resident #002 had a significant change their in condition.

Resident #002's progress notes, documented that RPN #120, RN #109, Resident Care Coordinator (RCC) #101 and DON #102 attended to resident #002’s fall prior to their transfer to the hospital. The circumstances of resident #002's fall were unclear.

Resident #002’s clinical records documented that the resident returned from the hospital on the same day.

A review of post fall assessments in PCC, showed that a post fall assessment was not completed for resident #002.

RPN #120 and RN #109 stated that a post fall assessment was not completed for resident #002 after their fall.

DON #103 said that post fall assessments were expected to be completed after the fall, but they directed staff to document the fall in progress notes as resident #002 was transferred to the hospital.

Progress notes were reviewed and did not document the factors contributing to resident #002's fall, the events leading up to the fall, and falls history and risk.

The licensee has failed to ensure that a post fall assessment using a clinically appropriate assessment instrument specifically designed for falls were conducted when resident #002 fell. [s. 49. (2)]

**Issued on this 23rd day of July, 2020**

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

**Original report signed by the inspector.**