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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 25, 2020	2020_792659_0016	014283-20, 014286-20, 014616-20	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

JANETM EVANS (659)

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): August 4, 5, 6, 7 and 18, 2020.

The following intakes were included in this inspection:
Log #014283-20\ Critical Incident #2358-000020-20 related to alleged staff to resident neglect
Log #014286-20\ Critical Incident #2358-000022-20 related to alleged staff to resident abuse
Log #014616-20\ Critical Incident #2358-000023-20 related to unexpected death of a resident

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Coordinator (RCC), Director of Quality Improvement (DQI), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

Observations were made of general care and cleanliness of residents and staff to resident interactions. A review of documentation including resident electronic records and hard copy of resident charts as well relevant policies and procedures was completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

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

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	Légende 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 has failed to ensure that resident #001 was protected from abuse by anyone.

a) A Critical Incident (CI) was submitted to the Ministry of Long Term Care (MLTC) which alleged verbal and physical abuse of resident #001 by PSW #107.

Subsection 2 (1) of the Act, defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self worth, that is made by anyone other than a resident.

Review of the home's investigation showed it was alleged that incidents occurred over two days in July 2020 and had been witness by other staff. PSW #107 was put off work pending an investigation and disciplinary action was taken in relation to this incident.

A head to toe assessment on Point Click Care (PCC) did not show evidence of any injury for resident #001.

Resident #001 was unable to recall the incident at the time of the inspection.

PSW #108 said PSW #107 yelled at the resident and forcefully repositioned the resident's arm during care.

PSW #104 said they were passing by resident #001's room when they heard an angry conversation where PSW #107 spoke to resident #001 in a loud, rude and condescending manner.

b) A CI was submitted to the MLTC which alleged PSW #107 refused to assist a resident with care over a two day period in July 2020.

Subsection 2 (1) of the Act, defines emotional abuse as
(a) "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

The home's investigation documented resident #002 asked for assistance with care. PSW #108 said the resident called as they needed assistance and they were incontinent. PSW #107 was witnessed telling the resident they could not keep calling staff. PSW

#107 told the resident they would assist them after their break.

The plan of care for resident #002 documented the resident required one person assistance for care.

Resident #002 said some staff spoke to them in a harsh voice. They acknowledged they had been told not to use their call bell and thought this was harsh and felt that they had been reprimanded by staff.

PSW #108 found resident #002 trying to self transfer. The resident said their nurse told them they could not use the call bell for help. PSW #107 was in the room and yelled at resident #002 for saying this. PSW #108 got resident #002 up and assisted the resident to the dining room as directed by PSW #107 despite the resident wanting to return to bed. The resident remained in the dining room when PSW #108 finished their shift at 1930 hours.

PSW #104 said they were in the dining room when resident #002 told them their nurse did not want to assist them with care and they looked upset.

PSW #108 said that every time resident #002 asked for assistance, PSW #107 told other staff to leave the resident.

RCC #101 said that resident #002 told them they felt like they had been reprimanded more than they should have been and asked if they were in trouble with the home.

The licensee failed to protect resident #001 from verbal abuse and resident #002 from emotional abuse by PSW #107. [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 resident #001 and resident #002 are free from abuse by anyone, to be implemented voluntarily.

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 the person who had reasonable grounds to suspect that abuse of a resident by anyone, immediately report the suspicion and the information upon which it was based to the the DIrector.

a) A Critical incident (CI) was reported to the Director on July 13, 2020. It related to an alleged incident of physical and verbal abuse of resident #001 by staff, which occurred July 11 - 12, 2020.

b) A CI was reported to the Director on July 13, 2020, related to incidents of alleged neglect of resident #002 by staff, which occurred between July 10 - 12, 2020.

The PSW reporting the incidents was a new staff to the home. They acknowledged they had not immediately reported the alleged incidents of abuse to the charge nurse. They stated that they thought they needed to wait until the Administrator was in the home to report the incident.

The Administrator and DOC acknowledged the alleged incidents involving resident #001 and resident #002 had not been immediately reported to the Director.

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of resident #001 and resident #002 by anyone, immediately report the suspicion and the information upon which it was based to the the Director. [s. 24. (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 staff understand what immediate reporting to the Director is, as well as who they are required to immediately report alleged incidents of abuse to at the home, to be implemented voluntarily.

Issued on this 27th day of August, 2020

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

Original report signed by the inspector.