

**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, 2021	2021_738753_0016	003258-21	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

KATHERINE ADAMSKI (753)

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, 9-12, 2021

**The following intake was completed during this critical incident (CI) inspection:
Log #003258-21/CI #2358-000004-21 related to falls prevention and management.**

**PLEASE NOTE: This inspection was conducted concurrently with follow-up
inspection #2021_738753_0015.**

**During the course of the inspection, the inspector(s) spoke with the Administrator,
Director of Nursing (DON), Public Health Representatives, Resident Care
Coordinator, Maintenance Manager and staff, Registered Practical Nurses (RPN),
residents, Personal Support Workers (PSW), and Housekeeping staff.**

**The inspector toured the home and observed residents and staff to resident care
provision, and reviewed relevant documentation.**

Inspector #706911 was also present on August 4-5, 2021, of this inspection.

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

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

- 1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).**
- 2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).**
- 3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**
- 4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**
- 5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was not restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

A resident was observed with a device applied. A staff member stated the resident required the device to prevent falls.

Multiple staff members stated the resident was not capable of removing the device, therefore it was considered a restraint. This resident's plan of care did not include the device.

When staff applied the device, it put the resident at risk of injury because they were not assessed for this intervention to ensure it was safe.

Sources: Observations of the resident, the resident's plan of care including care plan and kardex, and their medical chart, interviews with staff. [s. 30. (1) 3.]

Issued on this 3rd day of September, 2021

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

Original report signed by the inspector.