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

Central West District
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Original Public Report

Report Issue Date: May 1, 2023	
Inspection Number: 2023-1066-0002	
Inspection Type: Critical Incident System	
Licensee: LaPointe-Fisher Nursing Home, Limited	
Long Term Care Home and City: LaPointe-Fisher Nursing Home, Guelph	
Lead Inspector Janet Groux (606)	**Inspector Digital Signature** Janet Groux Digitally signed by Janet Groux Date: 2023.09.11 09:24:04 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 23, 24, 27-29, 2023.
The inspection occurred offsite on the following date(s): March 30, 2023.

The following intake(s) were inspected:

- Intake #00002126 regarding a change in a resident's condition of unknown cause.
- Intake #00019174 regarding an allegation of resident abuse.
- Intake #00019722 regarding a resident's fall.
- Intake #00020740 regarding a resident's unexpected death.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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)

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rationale and Summary:

A resident took another resident's belonging and would not give it back to the resident.

A Registered Practical Nurse (RPN) approached the resident to get the other resident's belonging which caused the resident to display a responsive behaviour. When this happened, the RPN handled the resident in a manner that was not aligned with their plan of care. The resident sustained an altered skin integrity as a result of the interaction with the RPN.

The resident's care plan said that when the resident was displaying a responsive behaviour, a number of interventions were to be initiated that would calm the resident down. Two Personal Support Workers (PSW) said that they witnessed the RPN handled the resident in an inappropriate manner and acknowledged that the RPN did not follow the resident's care plan.

Not following the resident plan of care caused the resident to display responsive behaviours which resulted in the resident to sustain injuries from the incident.

Sources: a resident's clinical records, and staff interviews. [606]

WRITTEN NOTIFICATION: Care Plans and Plans of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3)15.

The licensee has failed to ensure that a resident's plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's altered skin integrity when the physician did not assess the resident's altered skin integrity until a few weeks after it was identified.

Summary and Rationale:

A resident was transferred to the hospital and was diagnosed with a serious injury of unknown cause.

The resident was referred to the physician by documenting in the physician's book on identified dates to provide their interdisciplinary assessment of the new skin condition. An interdisciplinary assessment of the resident's skin condition was not conducted until a few weeks later when the physician assessed the resident. Once the physician assessed, medical treatments were ordered.

The physician said the physician's book was to be used by registered staff to communicate any concerns about a resident's health status. The physician acknowledged that they did not know why they did not assess the resident's altered skin integrity.

Failure to conduct an interdisciplinary assessment that included the physician for a resident's altered skin integrity delayed treatment and may have caused the resident further discomfort and risk of harm.

Sources: A Critical Incident (C) report, a resident's clinical records, the medical doctors' communication binder, and physician interview. [606]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure a resident was protected by abuse by a staff.

(1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, physical abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Summary and Rationale:

An RPN approached a resident to get back another resident's belonging from them which caused the resident to display a responsive behaviour. When this happened, the RPN interacted with the resident in a manner which was not aligned with their plan of care. The resident sustained an altered skin integrity as a result of this interaction.

The two PSWs who witnessed the incident stated the staff member treated the resident in a manner that was abusive and against the home's practice.

Sources: a resident's clinical records and interviews with staff. [606]