Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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 #/ Registre no	Type of Inspection / Genre d'inspection
Apr 18, 2017;	2017_532590_0002 (A1) (Appeal\Dir#: DR#070)	000541-17	Resident Quality Inspection

Licensee/Titulaire de permis

FIDDICK'S NURSING HOME LIMITED
437 FIRST AVENUE P.O. BOX 340 PETROLIA ON N0N 1R0

Long-Term Care Home/Foyer de soins de longue durée

FIDDICK'S NURSING HOME
437 FIRST AVENUE P.O. BOX 340 PETROLIA ON N0N 1R0

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

TERRI DALY (115) - (A1)(Appeal\Dir#: DR#070)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order #001 has been rescinded and substituted with a Director Order to reflect a decision of the Director on a review of the Inspector's order. The Directors review was completed on April 12, 2017.

Issued on this 18 day of April 2017 (A1)(Appeal\Dir#: DR#070)

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

Original report signed by the inspector.

Ontario

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

TERRI DALY (115) - (A1)(Appeal/Dir# DR#070)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 9, 11, 12, 13, 16, 17, 18, 19 and 20, 2017.

The following complaints were completed concurrently during this RQI:

LSAO log #011705-16/IL-44207-LO was related to sufficient staffing concerns, food temperature concerns, notification of family members and falls prevention.

LSAO log #018117-16/IL-45117-LO was related to lack of activities, falls preventions and resident charges.

LSAO log #028363-16/IL-46648-LO was related to sufficient staffing concerns and falls prevention equipment.

LSAO log #034727-16 was related to resident charges and falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), the Facility Nursing Manager, the Food Services Supervisor (FSS), the Activation Director, a Rehabilitation Coordinator, a Registered Dietitian (RD), a Physiotherapist, a Housekeeper, two Activity Aides, nine Registered Practical Nurses (RPN), seven Personal Support Workers (PSW), a representative of the Family Council, a representative of the Residents' Council, five family members and 20+ Residents'.

During the course of the inspection, the inspector(s) reviewed residents clinical records, relevant policies and procedures related to the inspection, one resident letter related to falls prevention equipment, one spreadsheet related to charges for falls prevention equipment, one Critical Incident System report, staff call in lists and staffing plans, bathing records, food temperature records, Family Council meeting minutes and the Residents' Council and Food for Thought meeting minutes.

During the course of the inspection, the inspector(s) toured all resident home areas, observed medication storage rooms, medication administration, the posting of required information, staff to resident interactions, recreational activities and infection prevention and control practices.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Food Quality

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

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

7 WN(s)
7 VPC(s)
1 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	Legendé 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the falls prevention program provided the

use of equipment, supplies, and devices.

A complaint inspection was initiated related to concerns from an identified resident's Substitute Decision Maker that the home was charging residents/families for falls prevention equipment.

During a staff interview the Rehabilitation Coordinator stated that the home currently uses hi lo beds, fall mats, pinning the call light, use of bed alarms, and tabs monitoring as part of the home's falls prevention equipment.
The Rehabilitation Coordinator acknowledged that all falls in the home are brought to their attention and as a multidisciplinary team, falls and the use of falls prevention equipment are assessed on an individual basis for each resident at risk of falls.
The Rehabilitation Coordinator shared that the home supplies falls prevention equipment and that the residents/family's are billed monthly for maintenance and batteries only after a 30 day trial to ensure the equipment is appropriate for the resident.

Rehabilitation Coordinator shared a list of residents utilizing and being billed monthly for falls prevention equipment.
A December 2016, Fiddick's Nursing Home (FNH) Equipment Maintenance Fees List was reviewed indicating that 28 residents were being billed monthly for falls prevention equipment used in the home.
The Rehabilitation Coordinator stated that four residents' families had purchased their own equipment and now pay equipment maintenance monthly through FNH. They further stated that five residents on the list have been using or requested use of the equipment despite an assessment indicating that the equipment was not required.

During a clinical record review for an identified resident and in an interview with Rehabilitation Coordinator, it was found that there is not a formal assessment process in place related to use of falls prevention equipment however documentation for the resident identified that "the bed alarm was removed because at this time another one had been damaged and no replacement was available." Also the resident's record indicated "Assessment: At this time, a bed alarm is not available as resident has broken several in the past."

In an interview the DRC and Administrator acknowledged that residents/families were being billed for falls prevention equipment, and that the regulation related to

the home's responsibility to provide falls prevention equipment is subject to interpretation.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of the inspection. The home has a history of one or more unrelated non-compliance. [s. 49. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)(Appeal/Dir# DR#070)
The following order(s) have been rescinded:CO# 001

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 the falls prevention program provided the use of equipment, supplies, and devices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee had failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Minimum Data Set (MDS) assessment dated August 2016, noted a decline in the continence level of an identified resident since their admission. Review of the care plan for the resident included a toileting focus that indicated that the resident required one staff assist and a toileting routine every two hours. It also included that the resident required constant supervision and was not to be left alone for any period of time when toileted. The last four completed continence assessments all indicated the resident required prompted voiding every two hours and the use of disposable pull ups.

A PSW stated during an interview that they do not provide any assistance for toileting of an identified resident as the resident toilets themself. The PSW stated that they will assist with peri care if required, but otherwise, that the resident does not require any assistance. The PSW also stated that the resident had recently been changed from a pull up to a pad as the resident's incontinence was not being managed by the pull up, and that the resident was unhappy with the change.

A PSW stated during an interview that an identified resident was independent with toileting, and did not require any supervision regarding toileting. The PSW did state that the resident was unhappy with the current incontinence pad that they had been assessed to require.

An RPN stated during an interview that the resident had been recently reassessed to require a change in incontinence product from a pull up to a pad as the pull up was not managing the incontinence of an identified resident. The RPN acknowledged that the resident was unhappy with the change.

An identified resident stated during an interview that staff did not assist them with toileting. The resident stated that they were upset that they had been changed from a pull up to a pad and would prefer the pull up back. Resident's Cognitive Performance Scale score was 2.

The DRC stated during an interview that it was the expectation that the care set in the plan of care, and based on assessments, would be provided to the resident.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of the inspection. The home has a history of non-compliance related to this area of legislation issued June 17, 2014, as a Written Notice (WN) in a Resident Quality

Inspection #2014_243504_0019. [s. 6. (7)]

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 the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Record review for an identified resident included a signed physician order on the Three Month Review (TMR) dated in December 2016, for "Carnation Instant Breakfast: Give 6 oz at breakfast, lunch and supper."

Record review for an identified resident included a note in Point Click Care (PCC)

from the Registered Dietitian (RD), dated January 17, 2017, and stated that the resident had been taken off Carnation Instant Breakfast in June 2016. Review of the physician order tab in PCC confirmed that the order had been discontinued by the RD in August 2016.

The Food Services Supervisor (FSS) stated that the Carnation Instant Breakfast had been discontinued to be provided to an identified resident in June 2016, following a verbal order from the RD after review during the quarterly care plan meeting regarding the resident.

The DRC stated during an interview that the RD manages the supplements provided to the residents within the home and orders and discontinues the use as assessed for each resident. The DRC stated that the expectation would have been that the orders of the RD would have been followed, by the dietary staff. The DRC also stated that it would also be expected that the use of the Carnation Instant Breakfast on the TMR form, viewed by the pharmacist and physician, would have been updated to reflect the discontinuation of the Carnation Instant Breakfast, as specified in the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A complaint was received from a family member indicating a resident's meals were being served at a colder temperature than preferred and that they had to send their meals back to be re-heated.

Review of the home's policy titled "Safe Food Policy", policy number D11.3 and last reviewed in February 2014, indicated the following direction related to the monitoring of food temperatures in the Procedure section 2:

"Temperatures must be taken at steam tables and recorded before being served to residents and guests."

Review of the steam table temperatures for three units from January 1 through to January 18, 2017, indicated the following about food temperatures:

On an identified unit, 63 temperatures or 13% of food temperatures were missing documentation.
On an identified unit, 65 temperatures or 13% of food temperatures were missing

documentation.
On an identified unit, 40 temperatures or 8% of food temperatures were missing documentation.

In an interview the FSS stated that the home's policy required that food temperatures were to be taken twice, once while in the kitchen and once again on the units prior to serving to residents. The FSS agreed that there were some missing and inappropriately documented temperatures on the records and shared that temperatures of all foods, hot or cold, should be taken and documented at each meal.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of the inspection. The home has a history of non-compliance related to this area of legislation issued May 17, 2016, as a Voluntary Plan of Correction (VPC) in a complaint inspection #2016_257518_0020. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Several complaints were received about the home working short staffed on numerous occasions.

In an interview the PSW stated that the direct care staff do work with insufficient staffing levels at times, and that bathing is one of the tasks that is sometimes missed when working short staffed. The spa PSW works 0630 - 1400 hours and will be pulled to work on the floor providing direct resident care if they are short staffed. The PSW further shared that the spa PSW is supposed to complete only four residents' baths/showers prior to helping on the floor, and that the evening shift PSW should make up the rest of the missed residents' baths/showers on their shift when working short staffed.

Review of bathing records indicated that the following residents' missed baths/showers on the identified dates and units:

An identified resident missed their bath/shower on a specified day in January 2017, on a specific unit.
An identified resident missed their bath/shower on a specified day in January 2017, on the specific unit.
An identified resident missed their bath/shower on a specified day in December 2016, on the specific unit.

Review of Point Of Care (POC) documentation and progress note documentation,

identified that there was no documented bed bath provided to the identified residents on their missed bath/shower days.

In an interview the PSW stated that two identified residents had missed their baths/showers on a specific day in January, 2017. They also stated that on one of the identified units staff had worked short that same morning.

Review of staffing levels and call-in documentation for the specific days in January 2017, and December 2016, was completed. The documentation indicated that one of the identified units had worked short a PSW on the specific day in January 2017, and the other identified unit had worked short a PSW on the specific day in December 2016. The home's management staff had attempted to replace these staff members with no success according to call-in lists reviewed for the identified shifts.

In an interview the DRC stated that three identified residents had missed their baths/showers on the identified dates and shared that the homes expectation is that residents are to be bathed/showered twice a week. They stated that the home does have a staffing plan in place and had followed their staffing plan regarding call-ins.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of the inspection. The home has a history of one or more unrelated non-compliance. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

Food for Thought and Resident Council meeting minutes from January 6, 2016, to December 7, 2016, were reviewed. There was no written documentation to indicate that a review of the meal or snack times was completed.

In an interview the Resident Council representative stated that they were unable to recall if the meal or snack times were reviewed at the Food for Thought or Resident Council meetings.

In an interview with the resident council liaison/Activity Aide and the FSS, they both indicated that the meal and snack times were not reviewed at the Food for Thought or Resident Council meetings.

The severity was determined to be a level 1 as there was minimum risk to the residents. The scope of this issue was widespread during the course of the inspection. The home has a history of one or more unrelated non-compliance. [s. 73. (1) 2.]

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 the dining and snack service includes a review of the meal and snack times by the Residents' Council, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that the results of the survey were documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3).

The home's Quality Improvement checklist indicated that the results of the survey are not documented or made available to the Residents' Council and Family Council, if any to seek their advice.

Review of the Family Council meeting minutes for its last three meetings indicated that the 2016 satisfaction survey results were not discussed with the Family Council.

In an interview with the Family Council President, they shared that up until last year the family council had not participated in the development of the satisfaction surveys and were not made aware of the survey results.

In an interview DRC stated that the results of the 2016 satisfaction survey were not communicated with the Family Council and that the home's expectation is that satisfaction survey results are summarized and shared with the Family Council. The DRC shared that the home does plan on sharing the results when they are

summarized. [s. 85. (4) (a)]

2. The licensee had failed to ensure that the results of the survey were documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3).

A review of Residents' Council meeting minutes from January 6, 2016 to December 7, 2016 was completed. There was no documentation related to the review or advice sought from the Residents' Council related to the satisfaction survey.

In an interview the Resident Council representative stated that they were unsure if the home had shared the results of the satisfaction survey and could not recall if advice was sought from the council in acting on the survey results.

In an interview with the Activity Director, they stated that the survey results had not been shared or advice sought from the Residents' Council related to the satisfaction survey results.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of the inspection. The home has a history of non-compliance related to this area of legislation issued June 17, 2014, as a Written Notice (WN) in a Resident Quality Inspection #2014_243504_0019. [s. 85. (4) (a)]

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 they document and make available to the Family and Resident's Council, the results of the satisfaction survey in order to seek the advice of the Council's about the survey, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Record review and interviews with an RPN and a PSW acknowledged that an identified resident utilized supportive devices while in bed for safety.

The home's policy titled "Use of Restraints - A-107", last reviewed November 2015, stated: "The need for the restraint and the Resident's response to the restraint shall be completed every 8 hours. The information will be documented by the Registered Nursing staff on the Restraint Observation Form (Located on each unit)."

Inspector interviewed a RPN, who stated that the registered staff were to record on each shift, the ongoing use and effectiveness of the restraint on the "form" in the binder on the unit but was unable to locate the binder.

Two RPN staff stated during an interview that the home used to have a restraint binder that included a "Restraint Observation Form" where the PSW's and the registered staff all recorded the use of the restraint, and that the registered staff would sign off on each shift. The staff members further stated that since the paper document was discontinued, they do not record an assessment every eight hours.

The DRC stated during an interview, that since the home's transition from the paper form to the electronic documentation system of PCC, it had not included a process for registered staff to record that the restraint had been reassessed and effectiveness of the restraining had been evaluated every eight hours as required. [s. 110. (2) 6.]

2. The licensee had failed to ensure that resident's condition had been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

A resident was observed during stage one sitting in a tilt wheelchair with two supportive devices in place. The resident was unable to remove the devices when asked.

During an interview RPN stated that the registered staff record the use and effectiveness of each restraint on each shift, on the "form" in the binder on the unit; however RPN was unable to locate the binder.

The DRC stated that the requirement to reassess the resident's condition and effectiveness of the restraint had not been followed through with an alternative place to document, and that a formal assessment as required was not completed.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of the inspection. The home has a history of one or more unrelated non-compliance. [s. 110. (2) 6.]

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 the resident's condition is reassessed and the effectiveness of the restraining is evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances, to be implemented voluntarily.

Issued on this 18 day of April 2017 (A1)(Appeal/Dir# DR#070)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Appeal/Dir# / Appel/Dir#:	DR#070 (A1)
Log No. / Registre no. :	000541-17 (A1)(Appeal/Dir# DR#070)
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 18, 2017;(A1)(Appeal/Dir# DR#070)
Licensee / Titulaire de permis :	FIDDICK'S NURSING HOME LIMITED 437 FIRST AVENUE, P.O. BOX 340, PETROLIA, ON, N0N-1R0
LTC Home / Foyer de SLD :	FIDDICK'S NURSING HOME 437 FIRST AVENUE, P.O. BOX 340, PETROLIA, ON, N0N-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MICHAEL FIDDICK

To FIDDICK'S NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)(Appeal/Dir# DR#070)
The following Order has been rescinded:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18 day of April 2017 (A1)(Appeal/Dir# DR#070)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TERRI DALY - (A1)(Appeal/Dir# DR#070)

Service Area Office /
Bureau régional de services : London