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 sous la Loi de 2007 sur 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 17, 2018	2018_533115_0008	017214-16, 033083-16, 008905-17, 015276-17, 024628-17, 025580-17, 004506-18	Critical Incident System

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), NANCY SINCLAIR (537)

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): May 8, 9 & 10, 2018

The following Critical Incident inspections were conducted:
Related to falls prevention:
Critical Incident Log #008905-17 / CI 2673-000005-17;
Critical Incident Log #015276-17 / CI 2673-000007-17;
Critical Incident Log #024628-17 / CI 2673-000009-17.

Related to prevention of abuse and neglect:
Critical Incident Log #025580-17 / CI 2673-0000010-17.

Related to medication administration:
Critical Incident Log #004506-18 / CI 2673-000005-18.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care, the Assistant Director of Resident Care, and three Registered Practical Nurses.

During the course of the inspection, the inspector(s) made observations of residents, reviewed relevant policies and procedures, as well as clinical records and plans of care for identified residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

2 WN(s)
1 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	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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A review of a Critical Incident System (CIS) Report submitted to the Ministry of Health and Long Term Care (MOHLTC) on a specific date, showed that a medication administration error resulted in a significant change in a resident's health condition.

The CIS report stated that the resident was flagged on two specific days to receive certain medications. On a specified date the resident was admitted to the hospital where they passed away.

The resident's care plan identified a specific focus, with specific interventions.

A review of the resident's Medication Administration Record (MAR) indicated that a protocol per the home's standing orders and as ordered by the physician had not be signed as given on two specific dates.

Investigative notes provided by the home stated that the staff responsible for administering the home's protocol to the resident on those dates told the Director of Resident Care (DRC) that they had given the medication, but had not signed the MAR. The staff member had told the DRC that they had put the medications in the resident's drink however the DRC noted that the particular drink had been discontinued.

The DRC said in an interview that the resident's care plan listed them as having potential for a specific concern, that the resident had standing orders related to the homes protocol as prescribed by the physician, that were not followed. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, when an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the residents' health condition, the Director was informed no later than one business day after the occurrence of the incident.

A Critical Incident System (CIS) report submitted by the home, on a specific date, and amended a few days later, included a description of a fall sustained by a resident, on a

specified date. The CIS report indicated that the resident had suffered an injury, and was transferred to hospital for treatment. While at hospital, the resident was also found to have sustained an additional injury from the fall.

The home's policy titled "Critical Incident System (CIS) – A-139", last reviewed September 2017, stated in part, "(3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital".

The Director of Care (DRC) stated during an interview that they were responsible to submit CIS reports within the home as per the requirements of their policy and the LTCHA. The DOC stated that they had been made aware of the incident for which reporting was required on a specific date by email, but did not submit the CIS report until a later date, which was greater than one business day following the incident.

The licensee has failed to ensure that the CIS report of the incident involving a resident was submitted to the MOHLTC no later than one business day after the occurrence of the incident. [s. 107. (3) 4.]

2. The licensee has failed to ensure that when they are required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 107

A Critical Incident System (CIS) report submitted by the home, on a specific date and amended months later, included a description of a resident to resident incident. The CIS report indicated that one of the residents was transferred to the hospital for evaluation.

The resident returned from the hospital on a certain date, however was transferred back to the hospital again due to further concerns. On a specified date the family discharged the resident from the nursing home.

The home's policy titled "Critical Incident System (CIS) – A-139", last reviewed September 2017, stated in part, "(4) A licensee who is required to inform the Director of

an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence.

The Director of Care (DRC) stated during an interview that they were responsible to submit CIS reports within the home as per the requirements of their policy and the LTCHA. They acknowledged that an amendment was not made to the CIS in relation to the long-term actions planned to correct the situation and prevent recurrence until some time after the resident's readmission to hospital and eventual discharge, which was greater than 10 days. [s. 107. (4) 4.]

Issued on this 28th day of June, 2018

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

Original report signed by the inspector.