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 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Feb 26, 2019	2019_605213_0008	033022-18	Complaint

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

RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 15, 2019

This inspection was completed related to a complaint, Infoline #IL-62750-LO related to the discharge of a resident.

This inspection was conducted concurrently while Inspector #145 was conducting inspection #2019_287145_0002 related to an emergency.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Associate Director of Care, the Behavioural Supports Ontario Nurse and the Director of the Erie-St. Clair Local Health Integration Network.

The Inspector also reviewed health records and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Admission and Discharge

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	
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 O.Reg 79/10, s. 145. When licensee may discharge

Specifically failed to comply with the following:

s. 145. (2) For the purposes of subsection (1), the licensee shall be informed by,
(a) in the case of a resident who is at the home, the Director of Nursing and Personal Care, the resident's physician or a registered nurse in the extended class attending the resident, after consultation with the interdisciplinary team providing the resident's care; or O. Reg. 79/10, s. 145 (2).
(b) in the case of a resident who is absent from the home, the resident's physician or a registered nurse in the extended class attending the resident. O. Reg. 79/10, s. 145 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that in the case of a resident who was absent from the home, the resident's physician or a registered nurse in the extended class attending the resident informed the licensee that the resident's requirements for care had changed and that, as a result, the home could not provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who came into contact with the resident and the licensee discharged the resident from the long term care home.

A complaint was received by the Ministry of Health and Long Term Care related to the discharge of a resident. In an interview with the complainant, they reported that the resident was discharged due to behaviours. They said there was no consultation or conversation with acute care or the Local Health Integration Network (LHIN) about what it would take to allow the resident to stay in the home. The complainant also said that as of the date of the interview, the resident still continued to have significant aggressive behaviours requiring interventions.

A record review of the resident's health records was completed. The resident had incidents of responsive behaviours on a daily basis including wandering, actively exit seeking, entering other residents' rooms, throwing things including furniture and equipment, paranoia, delusions, multiple incidents of physical and verbal aggression toward staff, seeking and hiding utensils including knives saying they were needed for protection, verbal aggression toward other residents, physical threats towards other residents, refusing care, refusing medications, etc.

In an interview with the Behavioural Supports Ontario (BSO) Nurse and the Associate Director of Care (ADOC), they said that the internal BSO team was highly involved in the

resident's care from admission. They said that geriatric mental health services were consulted and completed assessments as well as the external Behavioural Response Team throughout the resident's stay in the home. The BSO nurse and the ADOC demonstrated multiple assessments and individualized strategies that were trialed, implemented and communicated to staff to address the resident's responsive behaviours.

On an identified date, there was an incident where the resident caused significant physical harm to a staff member. Police and paramedics were called and the resident was transferred to acute care for assessment.

In an interview with the Director of Care (DOC), the DOC said that on an identified date, they told acute care that the home would not readmit the resident until there had been a substantial period of stability absent of violence. The following day, the DOC debriefed the resident's physician in the home regarding the incident that occurred. The physician told the DOC and the Administrator that this resident was not appropriate for long term care and recommended that the home refuse to accept the resident back into the home.

The physician documented this recommendation in a letter to the DOC, dated eleven days later. The physician also noted that they did not believe that this resident was appropriate for the facility. They stated the resident was highly violent with moderate dementia, a history of substance abuse, severe mental illness and living on the street, the resident was outside the scope of the nurses and personal support workers, and frankly outside of the physician's scope of practice as a community family physician providing nursing home care.

Six days after the incident in the home, the DOC sent a letter to the resident's substitute decision makers that the home was "declining a return to Fiddicks Nursing Home" as the home felt that the facility was "not the appropriate placement" for the resident "due to violent, unpredictable and aggressive behaviours".

The resident, who was absent from the home and in hospital, was discharged by the licensee from the long term care home, as informed by physician and Director of Care of the home, and not the resident's physician or a registered nurse in the extended class attending the resident. [s. 145. (2) (b)]

Issued on this 12th day of March, 2019

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

Original report signed by the inspector.