Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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
Mar 24, 2022	2022_834524_0007	017556-21, 018746-21, 019452-21, 001435-22	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

INA REYNOLDS (524), TATIANA PYPER (733564)

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): March 14, 15, and 16, 2022.

The following Critical Incident System (CIS) intakes were completed within this inspection:
CIS # 2673-000008-21 / Log # 017556-21 related to allegations of abuse
CIS # 2673-000010-21 / Log # 018746-21 related to responsive behaviours
CIS # 2673-000001-22 / Log # 001435-22 related to responsive behaviours.

The following Follow-up intake was completed within this inspection:
Log # 019452-21 follow-up to CO #001 related to medication management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, a Registered Nurse, a Registered Practical Nurse, Personal Support Workers, an Environmental Assistant and residents.

The inspector(s) also observed resident rooms and common areas, infection prevention and control practices within the home, residents and the care provided to them, reviewed clinical healthcare records and plans of care for identified residents, and relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 129.	CO #001	2021_607523_0032	524

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. 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 has failed to ensure that the home's Head Injury Routine policy was complied with.

Ontario Regulation 79/10, s. 48 (1) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury. Specifically, staff did not comply with the home's policy titled "Head Injury Policy" (HIR) that directed registered staff to implement a head injury routine whenever a resident experienced or was suspected of sustaining a head injury due to a fall or who had sustained an unwitnessed fall.

A review of a Critical Incident System (CIS) report submitted to the Director identified that a resident was injured by another resident during an altercation and was transferred to hospital for an assessment. The CIS identified that a HIR was initiated as a result of the altercation.

A review of the clinical record for the resident identified that registered staff initiated a HIR post incident when the resident was injured in the altercation, but the HIR was not consistently completed. A review of the clinical record identified that the resident also sustained a fall for which registered staff initiated a HIR, but the HIR was not consistently completed as per home’s policy.

The Director of Care (DOC) confirmed that the HIR forms were not completed according to the home’s policy for the resident. There was an increased risk to the resident related to the HIR not documented.

Sources: CIS report, the resident’s clinical records, the home’s policy titled “Head Injury Policy" number A-181 (Revision Date: August 2021), and interview with the DOC. [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 the home's Head Injury Routine policy is complied with for residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from verbal and emotional abuse by a Personal Support Worker (PSW).

Section 2 (1) of the Ontario Regulation 79/10 defines verbal abuse as “any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.”
Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as “any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.”

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care related to incidents of verbal and emotional abuse towards identified residents by a Personal Support Worker, resulting in minimal harm to the residents.

The home’s “Zero Tolerance of Abuse & Neglect” policy indicated that the home was committed to providing a safe and secure environment in which all residents are treated with dignity and respect and protected from all forms of abuse or neglect at all times.

The Assistant Director of Care (ADOC) stated that the outcome of the investigation determined abuse had occurred and the responses by the PSW towards the residents identified were inappropriate. The ADOC said that the staff member involved was no longer an employee of the home. There was minimal harm to residents as the residents were unable to recall the incident.

Sources: CIS report; the home’s policy titled “Zero Tolerance of Resident Abuse and Neglect”, number RC-02-01-01 last updated: June 2021; the home’s investigation documentation; clinical records for identified residents; and interviews with the ADOC, a PSW and other staff. [s. 19. (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 residents are protected from abuse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's abuse policy required any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse to report it immediately to the Administrator/ designate/ reporting manager or if unavailable, to the most senior Supervisor on shift at that time. In addition, anyone who suspected or witnessed abuse that caused or may cause harm to a resident was required to contact the Ministry of Health and Long-Term Care (Director) through the Action Line and follow provincial requirements.

The home's investigation records documented the following:
-A PSW had witnessed verbal and emotional abuse towards identified residents and had not informed the ADOC until the following day.
-A PSW reported during an investigation, that sometime in June or July 2021, a resident had made a sexual comment to staff while providing care and a PSW had flicked a resident's specific body part in response. The PSW had mentioned the incident to a registered practical nurse (RPN) on duty but could not remember who it was or a specific date for follow up with the RPN.
-A PSW reported during an investigation, that on an unknown date and time, a PSW had "yelled" at a resident and had caused the resident to cry.
-The home did not immediately call the Ministry of Long-Term Care after hours line and had not submitted a Critical Incident System (CIS) report within the required timeline.

The ADOC said that all the abuse allegations were not immediately reported, and some allegations had gone back months to the summer, and this did not meet the home's expectations. The ADOC said there was minimal long-term affect on the residents, and none could recall the incidents.

Sources: CIS report; the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting", number RC-02-01-02, last updated: June 2021; the home's investigation documentation; and an interview with the ADOC and a PSW. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident.

Review of the home's investigation notes documented the name of the staff member allegedly responsible for the verbal and emotional abuse of identified residents.

Review of the CIS report submitted by the home showed that the name of the staff member allegedly responsible for the abuse was not mentioned in the report.

The ADOC verified that the staff member’s name had not appeared in the critical incident report and was not aware that they should have been included.

Source: CIS report; the home’s investigation documentation; and interview with the ADOC. [s. 104. (1) 2.]

Issued on this 24th day of March, 2022

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

Original report signed by the inspector.